# TITLE 9. HEALTH SERVICES

## CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

***Editor's Note: The Office of the Secretary of State prints all Code Chapters on white paper (Supp 01-3).***

***Editor's Note: This Chapter contains rules which were adopted or amended under an exemption from the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6), pursuant to Laws 1992, Ch. 301, § 61 and Ch. 302, § 13, and Laws 1993, Ch. 6, § 34. Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Governor's Regulatory Review Council did not review these rules; AHCCCS was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is printed on blue paper.***

### ARTICLE 1. DEFINITIONS

*New Article 1, consisting of Sections R9-22-101 through R9-22-103, R9-22-105, and R9-22-106 through R9-22-112 adopted effective December 8, 1997 (Supp. 97-4).*

*Former Article 1, consisting of Section R9-22-101, repealed effective December 8, 1997 (Supp. 97-4).*

Section
R9-22-101. Location of Definitions
R9-22-102. Scope of Services Related Definitions
R9-22-103. Repealed
R9-22-104. Reserved
R9-22-105. General Provisions and Standards Related Definitions
R9-22-106. Request for Proposals (RFP) Related Definitions
R9-22-107. Standard for Payments Related Definitions
R9-22-108. Repealed
R9-22-109. Quality Control Related Definitions
R9-22-110. Repealed
R9-22-111. Reserved
R9-22-112. Behavioral Health Services Related Definitions
R9-22-113. Reserved
R9-22-114. AHCCCS Medical Coverage for Families and Individuals Related Definitions
R9-22-115. AHCCCS Medical Coverage for People Who Are Aged, Blind, or Disabled Related Definitions
R9-22-116. Repealed
R9-22-117. Enrollment Related Definitions
R9-22-118. Reserved
R9-22-119. Reserved
R9-22-120. Breast and Cervical Cancer Treatment Program Related Definitions

### ARTICLE 2. SCOPE OF SERVICES

Section
R9-22-201. General Requirements
R9-22-202. Repealed
R9-22-203. Repealed
R9-22-204. Inpatient General Hospital Services
R9-22-205. Attending Physician, Practitioner, and Primary Care Provider Services
R9-22-206. Organ and Tissue Transplant Services
R9-22-207. Dental Services
R9-22-208. Laboratory, Radiology, and Medical Imaging Services
R9-22-209. Pharmaceutical Services
R9-22-210. Emergency Medical and Behavioral Health Services
R9-22-211. Transportation Services
R9-22-212. Medical Supplies, Durable Medical Equipment, and Orthotic and Prosthetic Devices
R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)
R9-22-214. Repealed
R9-22-215. Other Medical Professional Services
R9-22-216. NF, Alternative HCBS Setting, or HCBS
R9-22-217. Services Included in the State and Federal Emergency Services Programs
R9-22-218. Repealed

### ARTICLE 3. REPEALED

*Article 3, consisting of Sections R9-22-301 through R9-22-319 and R9-22-321 through R9-22-344, repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section R9-22-320 repealed December 13, 1993 (Supp. 93-4).*

### ARTICLE 4. REPEALED

Section
R9-22-401. Repealed
R9-22-402. Repealed
R9-22-403. Repealed
R9-22-404. Repealed
R9-22-405. Repealed
R9-22-406. Repealed

### ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Section
R9-22-501. Pre-existing Conditions
R9-22-502. Availability and Accessibility of Service
R9-22-503. Repealed
R9-22-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions
R9-22-505. Approval of Advertisements and Marketing Materials
R9-22-506. Repealed
R9-22-507. Member Record
R9-22-508. Limitation of Benefit Coverage for Illness or Injury due to Catastrophe
R9-22-509. Transition and Coordination of Member Care
R9-22-510. Transfer of Members
R9-22-511. Fraud or Abuse
R9-22-512. Release of Safeguarded Information by the Administration and Contractors
R9-22-513. Discrimination Prohibition
R9-22-514. Equal Opportunity
R9-22-515. Repealed
R9-22-516. Renumbered
R9-22-517. Renumbered
R9-22-518. Information to Enrolled Members
R9-22-519. Repealed
R9-22-520. Expired
R9-22-521. Program Compliance Audits
R9-22-522. Quality Management/Utilization Management (QM/UM) Requirements
R9-22-523. Expired
R9-22-524. Continuity of Care
R9-22-525. Repealed
R9-22-526. Renumbered
R9-22-527. Renumbered

**ARTICLE 6. RFP AND CONTRACT PROCESS**

*Article 6, consisting of Sections R9-22-601 through R9-22-604, adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1).*

*Article 6, consisting of Sections R9-22-601 through R9-22-605, repealed by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1).*

*Article 6, consisting of Sections R9-22-601 through R9-22-604, adopted effective July 16, 1985.*

*Former Article 6, consisting of Sections R9-22-601 through R9-22-603, repealed effective October 1, 1983.*



**ARTICLE 7. STANDARDS FOR PAYMENTS**



**ARTICLE 8. REPEALED**

*Article 8, consisting of Sections R9-22-801 through R9-22-804 and Exhibit A, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).*



**ARTICLE 9. QUALITY CONTROL**

*Article 22, consisting of Sections R9-22-901 through R9-22-908, adopted effective August 29, 1985.*

*Former Article 22, consisting of Section R9-22-901, repealed effective October 1, 1983.*



**ARTICLE 10. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES**

*Article 10, consisting of Section R9-22-1001 through R9-22-1002, adopted effective November 7, 1997 (Supp. 97-4).*

*Article 10, consisting of Section R9-22-1001 through R9-22-1002, repealed effective November 7, 1997 (Supp. 97-4).*

*Article 10 consisting of Sections R9-22-1001 and R9-22-1002 adopted effective October 1, 1985.*



**ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS**

*Article 11 consisting of Sections R9-22-1101 through R9-22-1104 adopted effective October 1, 1986.*



**ARTICLE 12. BEHAVIORAL HEALTH SERVICES**

*Article 12, consisting of Sections R9-22-1201 through R9-22-1208, repealed; new Article 12, consisting of Sections R9-22-1201 through R9-22-1208 adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4).*

**ARTICLE 13. REPEALED**

*Article 13, consisting of Sections R9-22-1301 through R9-22-1309, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 13 is now in 9 A.A.C. 34 (Supp. 04-1).*

*Article 13, consisting of Sections R9-22-1301 through R9-22-1309, adopted effective September 9, 1998 (Supp. 98-3).*



**ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR FAMILIES AND INDIVIDUALS**

*Article 14, consisting of Sections R9-22-1401 through R9-22-1436, repealed; new Article 14, consisting of Sections R9-22-1401 through R9-22-1433 made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).*

*Article 14, consisting of Sections R9-22-1401 through R9-22-1436, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).*



**ARTICLE 15. AHCCCS MEDICAL COVERAGE FOR PEOPLE WHO ARE AGED, BLIND, OR DISABLED**

*Article 15, consisting of Sections R9-22-1501 through R9-22-1508, repealed; new Article 15, consisting of Sections R9-22-1501 through R9-22-1505 made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).*

*Article 15, consisting of Sections R9-22-1501 through R9-22-1508, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).*



**ARTICLE 16. REPEALED**

*Article 16, consisting of Sections R9-22-1601 through R9-22-1636, repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).*

*Article 16, consisting of Sections R9-22-1601 through R9-22-1613, R9-22-1615 through R9-22-1620, R9-22-1622 through R9-22-1631, R9-22-1633, R9-22-1634, and R9-22-1636, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).*

## ARTICLE 17. ENROLLMENT

*Article 17, consisting of Sections R9-22-1701 through R9-22-1704, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).*



## ARTICLE 18. RESERVED

## ARTICLE 19. FREEDOM TO WORK

*Article 19, consisting of Sections R9-22-1901 through R9-22-1922, made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).*



## ARTICLE 20. BREAST AND CERVICAL CANCER TREATMENT PROGRAM



## ARTICLE 21. TRAUMA AND EMERGENCY SERVICES FUND

*Article 21, consisting of Sections R9-22-2101 through R9-22-2103, made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).*



## ARTICLE 1. DEFINITIONS

### R9-22-101. Location of Definitions

**A.** Location of definitions. Definitions applicable to this Chapter are found in the following:

| Definition | Section or Citation |
|---|---|
| "Accommodation" | R9-22-107 |
| "Act" | R9-22-114 |
| "Active case" | R9-22-109 |
| "ADHS" | R9-22-112 |
| "Administration" | A.R.S. § 36-2901 |
| "Administrative law judge" | R9-22-108 |
| "Administrative review" | R9-22-108 |
| "Advanced Life Support" or "ALS" | R9-25-101 |
| "Adverse action" | R9-22-114 |
| "Affiliated corporate organization" | R9-22-106 |
| "Aged" | 42 U.S.C. 1382c(a)(1)(A) and R9-22-115 |
| "Aggregate" | R9-22-107 |
| "AHCCCS" | R9-22-101 |
| "AHCCCS inpatient hospital day or days of care" | R9-22-107 |
| "AHCCCS registered provider" | R9-22-101 |
| "Ambulance" | A.R.S. § 36-2201 |
| "Ancillary department" | R9-22-107 |
| "Annual assessment period" | R9-22-109 |
| "Annual assessment period report" | R9-22-109 |
| "Annual enrollment choice" | R9-22-117 |
| "Appellant" | R9-22-114 |
| "Applicant" | R9-22-101 |
| "Application" | R9-22-101 |
| "Assignment" | R9-22-101 |
| "Attending physician" | R9-22-101 |
| "Authorized representative" | R9-22-114 |
| "Auto-assignment algorithm" | R9-22-117 |
| "Baby Arizona" | R9-22-114 |
| "Basic Life Support" or "BLS" | R9-25-101 |
| "Behavior management services" | R9-22-112 |
| "Behavioral health evaluation" | R9-22-112 |
| "Behavioral health medical practitioner" | R9-22-112 |
| "Behavioral health professional" | R9-20-101 |
| "Behavioral health service" | R9-22-112 |
| "Behavioral health technician" | R9-20-101 |
| "Behavior management services" | R9-22-112 |
| "BHS" | R9-22-114 |
| "Billed charges" | R9-22-107 |
| "Blind" | R9-22-115 |
| "Board-eligible for psychiatry" | R9-22-112 |
| "Burial plot" | R9-22-114 |
| "Capital costs" | R9-22-107 |
| "Capped fee-for-service" | R9-22-101 |
| "Caretaker relative" | R9-22-114 |

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|---|---|
| "Case" | R9-22-109 |
| "Case record" | R9-22-109 |
| "Case review" | R9-22-109 |
| "Cash assistance" | R9-22-114 |
| "Categorically-eligible" | R9-22-101 |
| "Certified psychiatric nurse practitioner" | R9-22-112 |
| "Clean claim" | A.R.S. § 36-2904 |
| "Clinical supervision" | R9-22-112 |
| "CMDP" | R9-22-117 |
| "CMS" | R9-22-101 |
| "Complainant" | R9-22-108 |
| "Continuous stay" | R9-22-101 |
| "Contract" | R9-22-101 |
| "Contractor" | A.R.S. § 36-2901 |
| "Copayment" | R9-22-107 |
| "Corrective action plan" | R9-22-109 |
| "Cost-to-charge ratio" | R9-22-107 |
| "Covered charges" | R9-22-107 |
| "Covered services" | R9-22-102 |
| "CPT" | R9-22-107 |
| "CRS" | R9-22-114 |
| "Cryotherapy" | R9-22-120 |
| "Date of eligibility posting" | R9-22-107 |
| "Date of notice" | R9-22-108 |
| "Day" | R9-22-101 |
| "DCSE" | R9-22-114 |
| "De novo hearing" | 42 CFR 431.201 |
| "Dentures" | R9-22-102 |
| "Department" | A.R.S. § 36-2901 |
| "Dependent child" | A.R.S. § 46-101 |
| "DES" | R9-22-101 |
| "Diagnostic services" | R9-22-102 |
| "Director" | R9-22-101 |
| "Disabled" | R9-22-115 |
| "Discussions" | R9-22-106 |
| "Disenrollment" | R9-22-117 |
| "District" | R9-22-109 |
| "DME" | R9-22-102 |
| "DRI inflation factor" | R9-22-107 |
| "E.P.S.D.T. services" | 42 CFR 441 Subpart B |
| "Eligible person" | A.R.S. § 36-2901 |
| "Emergency medical condition" | 42 U.S.C. 1396b(v)(3) |
| "Emergency medical services" | R9-22-102 |
| "Emergency services costs" | A.R.S. § 36-2903.07 |
| "Encounter" | R9-22-107 |
| "Enrollment" | R9-22-117 |
| "Enumeration" | R9-22-101 |
| "Equity" | R9-22-101 |
| "Experimental services" | R9-22-101 |
| "Error" | R9-22-109 |
| "FAA" | R9-22-114 |
| "Facility" | R9-22-101 |
| "Factor" | 42 CFR 447.10 |
| "FBR" | R9-22-101 |
| "Fee-For-Service" or "FFS" | R9-28-101 |
| "FESP" | R9-22-101 |
| "Finding" | R9-22-109 |
| "First-party liability" | R9-22-110 |
| "Foster care maintenance payment" | 42 U.S.C. 675(4)(A) |
| "Federal poverty level" ("FPL") | A.R.S. § 1-215 |
| "FQHC" | R9-22-101 |
| "Grievance" | R9-22-108 |
| "GSA" | R9-22-101 |
| "Health care practitioner" | R9-22-112 |
| "Hearing" | R9-22-108 |
| "Hearing aid" | R9-22-102 |
| "Home health services" | R9-22-102 |
| "Homebound" | R9-22-114 |
| "Hospital" | R9-22-101 |
| "Intermediate Care Facility for the Mentally Retarded" or "ICF-MR" | 42 CFR 483 Subpart I |
| "ICU" | R9-22-107 |
| "IHS" | R9-22-117 |
| "IMD" | 42 CFR 435.1009 and R9-22-112 |
| "Income" | R9-22-114 |
| "Inmate of a public institution" | 42 CFR 435.1009 |
| "Interested party" | R9-22-106 |
| "LEEP" | R9-22-120 |
| "Level I trauma center" | R9-22-2101 |
| "License" or "licensure" | R9-22-101 |
| "Mailing date" | R9-22-114 |
| "Management evaluation review" | R9-22-109 |
| "Medical education costs" | R9-22-107 |
| "Medical expense deduction" | R9-22-114 |
| "Medical record" | R9-22-101 |
| "Medical review" | R9-22-107 |
| "Medical services" | A.R.S. § 36-401 |
| "Medical supplies" | R9-22-102 |
| "Medical support" | R9-22-114 |
| "Medically necessary" | R9-22-101 |
| "Medicare claim" | R9-22-107 |
| "Medicare HMO" | R9-22-101 |
| "Member" | A.R.S. § 36-2901 |
| "Mental disorder" | A.R.S. § 36-501 |
| "New hospital" | R9-22-107 |
| "Nursing facility" or "NF" | 42 U.S.C. 1396r(a) |
| "NICU" | R9-22-107 |
| "Noncontracting provider" | A.R.S. § 36-2901 |
| "Nonparent caretaker relative" | R9-22-114 |
| "Notice of Findings" | R9-22-109 |
| "OAH" | R9-22-108 |
| "Occupational therapy" | R9-22-102 |
| "Offeror" | R9-22-106 |
| "Ownership interest" | 42 CFR 455.101 |
| "Operating costs" | R9-22-107 |
| "Outlier" | R9-22-107 |
| "Outpatient hospital service" | R9-22-107 |
| "Ownership change" | R9-22-107 |
| "Partial Care" | R9-22-112 |
| "Party" | R9-22-108 |
| "Peer group" | R9-22-107 |
| "Performance measures" | R9-22-109 |
| "Pharmaceutical service" | R9-22-102 |
| "Physical therapy" | R9-22-102 |
| "Physician" | R9-22-102 |
| "Prior period coverage" or "PPC" | R9-22-107 |
| "Post-stabilization care services" | 42 CFR 422.113 |
| "Practitioner" | R9-22-102 |
| "Pre-enrollment process" | R9-22-114 |
| "Preponderance of evidence" | R9-22-109 |
| "Prescription" | R9-22-102 |
| "Primary care provider (PCP)" | R9-22-102 |
| "Primary care provider services" | R9-22-102 |
| "Prior authorization" | R9-22-102 |
| "Private duty nursing services" | R9-22-102 |
| "Proposal" | R9-22-106 |
| "Prospective rates" | R9-22-107 |
| "Prospective rate year" | R9-22-107 |
| "Psychiatrist" | R9-22-112 |
| "Psychologist" | R9-22-112 |
| "Psychosocial rehabilitation services" | R9-22-112 |
| "Qualified alien" | A.R.S. § 36-2903.03 |

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|---|---|
| "Quality management" | R9-22-105 |
| "Radiology" | R9-22-102 |
| "Random sample" | R9-22-109 |
| "RBHA" | R9-22-112 |
| "Rebasing" | R9-22-107 |
| "Referral" | R9-22-101 |
| "Rehabilitation services" | R9-22-102 |
| "Reinsurance" | R9-22-107 |
| "Remittance advice" | R9-22-107 |
| "Resources" | R9-22-114 |
| "Respiratory therapy" | R9-22-102 |
| "Respondent" | R9-22-108 |
| "Responsible offeror" | R9-22-106 |
| "Responsive offeror" | R9-22-106 |
| "Review" | R9-22-114 |
| "Review period" | R9-22-109 |
| "RFP" | R9-22-106 |
| "Scope of services" | R9-22-102 |
| "SDAD" | R9-22-107 |
| "Section 1115 Waiver" | A.R.S. § 36-2901 |
| "Service location" | R9-22-101 |
| "Service site" | R9-22-101 |
| "SESP" | R9-22-101 |
| "S.O.B.R.A." | R9-22-101 |
| "Specialist" | R9-22-102 |
| "Specified relative" | R9-22-114 |
| "Speech therapy" | R9-22-102 |
| "Spendthrift restriction" | R9-22-114 |
| "Spouse" | R9-22-101 |
| "SSA" | 42 CFR 1000.10 |
| "SSI" | 42 CFR 435.4 |
| "SSN" | R9-22-101 |
| "Stabilize" | 42 U.S.C. 1395dd |
| "Standard of care" | R9-22-101 |
| "Sterilization" | R9-22-102 |
| "Subcontract" | R9-22-101 |
| "Submitted" | A.R.S. § 36-2904 |
| "Summary report" | R9-22-109 |
| "SVES" | R9-22-114 |
| "Third-party" | R9-22-110 |
| "Third-party liability" | R9-22-110 |
| "Tier" | R9-22-107 |
| "Tiered per diem" | R9-22-107 |
| "Title IV-D" | R9-22-114 |
| "Title IV-E" | R9-22-114 |
| "Tolerance level" | R9-22-109 |
| "Trauma and Emergency Services Fund" | A.R.S. § 36-2903.07 |
| "Unrecovered trauma readiness costs" | R9-22-2101 |
| "Utilization management" | R9-22-105 |
| "WWHP" | R9-22-120 |

**B.** General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"AHCCCS registered provider" means a provider or noncontracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A); and

Meets license or certification requirements to provide AHCCCS covered services.

"Applicant" means a person who submits or whose authorized representative submits, a written, signed, and dated application for AHCCCS benefits.

"Application" means an official request for AHCCCS medical coverage made under this Chapter.

"Assignment" means enrollment of a member with a contractor by the Administration.

"Attending physician" means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a fee-for-service member.

"Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific AHCCCS-covered service or equipment provided to a member. A payment is made in accordance with an upper, or capped, limit established by the Director.

"Categorically-eligible" means a person who is eligible under A.R.S. §§ 36-2901(6)(a)(i), (ii), or (iii) and 36-2934.

"CMS" means the Centers for Medicare and Medicaid Services.

"Continuous stay" means the period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

"Contract" means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and this Chapter.

"Day" means a calendar day unless otherwise specified.

"DES" means the Department of Economic Security.

"Director" means the Director of the Administration or the Director's designee.

"Eligible person" means a person as defined in A.R.S. § 36-2901.

"Enumeration" means the assignment of a specific nine-digit identification number to a person by the Social Security Administration.

"Equity" means the county assessor full cash or market value of a resource minus valid liens, encumbrances, or both.

"Experimental services" means services that are associated with treatment or diagnostic evaluation that meets one or more of the following criteria:

Is not generally and widely accepted as a standard of care in the practice of medicine in the United States;

Does not have evidence of safety and effectiveness documented in peer reviewed articles in medical journals published in the United States; or

Lacks authoritative evidence by the professional medical community of safety and effectiveness because the services are rarely used, novel, or relatively unknown in the professional medical community.

"Facility" means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution, under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.

"FBR" means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

"FESP" means a federal emergency services program covered under R9-22-217, to treat an emergency medical condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

"FQHC" means federally qualified health center.

"GSA" means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with that contractor.

"Hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.

"License" or "licensure" means a nontransferable authorization that is awarded based on established standards in law, is issued by a state or a county regulatory agency or board, and allows a health care provider to lawfully render a health care service.

"Medical record" means all documents that relate to medical and behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that are kept at the site of the provider.

"Medically necessary" means a covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or prolong life.

"Medicare HMO" means a health maintenance organization that has a current contract with Centers for Medicare and Medicaid for participation in the Medicare program under 42 CFR 417(L).

"Referral" means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

"Service location" means a location at which a member obtains a covered health care service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

"Service site" means a location designated by a contractor as the location at which a member is to receive covered health care services.

"SESP" means state emergency services program covered under R9-22-217 to treat an emergency medical condition for a qualified alien or noncitizen who is determined eligible under A.R.S. § 36-2901.06.

"S.O.B.R.A." means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).

"Spouse" means a person who has entered into a contract of marriage, recognized as valid by Arizona.

"SSN" means social security number.

"Standard of care" means a medical procedure or process that is accepted as treatment for a specific illness, or injury, medical condition through custom, peer review, or consensus by the professional medical community.

"Subcontract" means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member;

A marketing organization; or

Any other organization or person who agrees to perform any administrative function or service for a contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a contract.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-101 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-101 repealed, former Sections R9-22-102 and R9-22-301 renumbered as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency by adding new paragraphs (24), (46), (84) and (91) and renumbering accordingly effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Amended as an emergency by adding new paragraphs (2) and (15) and renumbering accordingly effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment added paragraphs (2) and (15) and renumbered accordingly effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended paragraphs (10) and (15) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended by deleting paragraphs (39) and (62) and renumbering accordingly effective July 1, 1988 (Supp. 88-3). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted effective December 8, 1997 (Supp. 97-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 2435, effective

June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).

**R9-22-102. Scope of Services Related Definitions**

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Covered services" means the health and medical services described in Articles 2 and 12 of this Chapter as being eligible for reimbursement by AHCCCS.

"Dentures" means a partial or complete set of artificial teeth and services that are determined to be medically necessary and the primary treatment of choice, or an essential part of an overall treatment plan, designed to alleviate a medical condition as determined by the primary care provider in consultation with the dental service provider.

"Diagnostic services" means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.

"DME" means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.

"Emergency medical services" means services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

Placing the patient's health in serious jeopardy;

Serious impairment to bodily functions; or

Serious dysfunction of any bodily organ or part.

"Hearing aid" means an instrument or device designed for, or represented by the supplier as aiding or compensating for impaired or defective human hearing, and any parts, attachments, or accessories of the instrument or device.

"Home health services" means the services that are provided by a home health agency that coordinates in-home intermittent services for curative, habilitative care. This includes home-health aide services, licensed nurse services, and medical supplies, equipment, and appliances.

"Medical supplies" means consumable items that are designed specifically to meet a medical purpose.

"Occupational therapy" means the medically prescribed treatment provided by or under the supervision of a licensed occupational therapist, to restore or improve an individual's ability to perform tasks required for independent functioning.

"Pharmaceutical service" means medically necessary medications that are prescribed by a physician, practitioner, or dentist under R9-22-209.

"Physical therapy" means treatment services to restore or improve muscle tone, joint mobility, or physical function provided by or under the supervision of a registered physical therapist.

"Physician" means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

"Practitioner" means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15.

"Prescription" means an order to provide covered services, which is signed or transmitted by a provider authorized to prescribe or order services.

"Primary care provider" or "PCP" means an individual who meets the requirements of A.R.S. § 36-2901(12) and (13), and who is responsible for the management of a member's health care.

"Primary care provider services" means healthcare services provided by and within the scope of practice, as defined by law, of a licensed physician, certified nurse practitioner, or licensed physician assistant.

"Prior authorization" means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services contingent on the medical necessity of the services.

"Private duty nursing services" means nursing services provided to a member who requires more individual and continuous care than is available from a visiting nurse, or routinely provided by the nursing staff of a nursing facility or ICF-MR, and that are provided by a registered nurse or licensed practical nurse.

"Radiology" means professional and technical services rendered to provide medical imaging, radioisotope services, and radiation oncology.

"Rehabilitation services" means physical, occupational, and speech therapies, and items to assist in improving or restoring a person's functional level.

"Respiratory therapy" means treatment services to restore, maintain, or improve respiratory functions that are provided by, or under the supervision of, a respiratory therapist licensed according to A.R.S. Title 32, Chapter 35.

"Scope of services" means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter.

"Specialist" means a Board eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board eligible means a physician who meets all the requirements for certification but has not tested for, or has not been issued certification.

"Speech therapy" means medically prescribed diagnostic and treatment services provided by, or under the supervision of, a certified speech therapist.

"Sterilization" means a medically necessary procedure, not for purpose of family planning, to render an eligible person or member barren in order to:

Prevent the progression of disease, disability, or adverse health conditions; or

Prolong life and promote physical health.

**Historical Note**
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-102 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1092 (Supp. 82-4). Former Section R9-22-102 renumbered together with former Section R9-22-301 as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). New Section adopted effective December 8, 1997 (Supp. 97-4). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

**R9-22-103. Repealed**

**Historical Note**
Adopted effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-104. Reserved**

**R9-22-105. General Provisions and Standards Related Definitions**
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Quality management" means a methodology and activity used by professional health personnel through a formal program involving multiple organizational components and committees to:

Assess the degree of conformance to desired medical standards and practices and;

Improve or maintain quality service and care.

"Utilization management" means a methodology used by professional health personnel that assesses the medical indications, appropriateness, and efficiency of care provided.

**Historical Note**
Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2).

**R9-22-106. Request for Proposals (RFP) Related Definitions**
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Affiliated corporate organization" means any organization that has ownership or management interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation relationships. 42 CFR 455.101, September 30, 1986, is incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

"Discussions" means an oral or written exchange of information or any form of negotiation.

"Interested party" means an actual or prospective offeror whose economic interest may be directly affected by the issuance of an RFP, the award of a contract, or by the failure to award a contract.

"Offeror" means a person or entity that submits a proposal to the Administration in response to an RFP.

"Proposal" means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.

"Responsible offeror" means a person or entity who has the capability to perform the contract requirements and that ensures good faith performance.

"Responsive offeror" means a person or entity that submits a proposal that conforms in all material respects to an RFP.

"RFP" means Request for Proposals, including all documents, whether attached or incorporated by reference, that are used by the Administration for soliciting a proposal under 9 A.A.C. 22, Article 6.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2).

**R9-22-107. Standard for Payments Related Definitions**
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Accommodation" means bed and board services provided to a patient during an inpatient hospital stay and includes all staffing, supplies, and equipment. The accommodation is semi-private except when the member must be isolated for medical reasons. Other types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit in which bed and board are provided.

"Aggregate" means the combined amount of hospital payments for covered services provided within and outside the service area.

"AHCCCS inpatient hospital day or days of care" means each day of an inpatient stay for a member, beginning with the day of admission, including the day of death, but excluding the day of discharge, provided that all medical necessity and medical review requirements are met.

"Ancillary department" means the department of a hospital that provides ancillary services and outpatient services, as defined in the Medicare provider Reimbursement Manual.

"Billed charges" means charges that a hospital includes on a claim for providing hospital services to a member consistent with the rates and charges filed by the hospital with the Arizona Department of Health Services.

"Capital costs" means capital-related costs, as defined in the Medicare provider Reimbursement Manual, Chapter 28, such as building and fixtures, and movable equipment.

"Copayment" means a monetary amount, specified by the Director, that a member pays directly to a contractor or provider at the time covered services are rendered.

"Cost-to-charge ratio" means a hospital's costs for providing covered services divided by the hospital's covered charges for the same services.

"Covered charges" means billed charges that represent medically necessary, reasonable, and customary items of expense for AHCCCS-covered services that meet medical review criteria of the Administration or contractor.

"CPT" means current procedural terminology, the manual published and updated by the American Medical Association, which is a nationally accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and provides a uniform language to accurately designate medical, surgical, and diagnostic services.

"Date of eligibility posting" means the date a member's eligibility information is entered into the AHCCCS pre-paid medical management information system (PMMIS).

"DRI inflation factor" means the Data Resources Inc., Health Care Financing Administration hospital input price index for prospective hospital reimbursement, which is published by DRI/McGraw-Hill.

"Encounter" means a record of medical service, submitted by a contractor and processed by AHCCCS, that is rendered by an AHCCCS registered provider to a member who is enrolled with the contractor on the date of service, and for which the contractor incurs financial liability.

"ICU" means the intensive care unit of a hospital.

"Medical education costs" means direct hospital costs for intern and resident salaries, fringe benefits, program costs, nursing school education, and paramedical education, which are defined in the Medicare provider Reimbursement Manual, Chapter 28.

"Medical review" means a review involving clinical judgment of a claim or a request for a service before or after it is paid or rendered to ensure that services provided to a member are medically necessary covered services and that required authorizations are obtained by the provider. The criteria for medical review are established by the Administration or contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

"Medicare claim" means a claim for Medicare covered services for a member with Medicare coverage.

"New hospital" means a hospital for which Medicare Cost Report (Health Care Finance Administration form-2552) data and claim and encounter data are not available for hospital rate development from any owner or operator of the hospital, during either the initial prospective rate year or rebasing.

"NICU" means the neonatal intensive care unit of a hospital that is classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.

"Operating costs" means an AHCCCS allowable accommodation and ancillary department hospital costs excluding capital and medical education costs.

"Outlier" means a hospital claim or encounter in which the operating costs per day for an AHCCCS inpatient hospital stay meet the criteria described in R9-22-712.

"Outpatient hospital service" means a service provided in an outpatient hospital setting that does not result in an admission.

"Ownership change" means a change in a hospital's owner, lessor, or operator under 42 CFR 489.18(A).

"Peer group" means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services.

"PPC" means prior period coverage. PPC is the period of time, prior to the member's enrollment, during which a member is eligible for covered services. The time-frame is the first day of the month of application or the first eligible month, whichever is later, to the day a member is enrolled with a contractor.

"Prospective rates" means inpatient or outpatient hospital rates defined by the Administration in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, and first-and third-party payments regardless of billed charges or individual hospital costs.

"Prospective rate year" means the period from October 1 of each year to September 30 of the following year, except for the initial prospective rate year, which is between March 1, 1993, and September 30, 1994.

"Rebasing" means the process by which new Medicare Cost Report data (Health Care Finance Administration form-2552), and AHCCCS claim and encounter data are collected and analyzed to reset periodically the inpatient hospital tiered per diem rates or the outpatient hospital cost-to-charge ratios.

"Reinsurance" means a risk-sharing program provided by the Administration to contractors for the reimbursement of certain contract service costs incurred by a member beyond a certain monetary threshold.

"Remittance advice" means an electronic or paper document submitted to an AHCCCS registered provider by the Administration to explain, as applicable:

How submitted claims were paid,

Why submitted claims were denied or adjusted,

Why submitted claims were pended, and

How to grieve the Administration's adverse action according to Article 8 of this Chapter.

"SDAD" means same day admit and discharge, which is a hospital stay with the admit and discharge occurring on the same calendar day.

"Tier" means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure or revenue codes, peer group, or NICU classification level, or any combination of these items.

"Tiered per diem" means a payment structure in which payment is made on a per-day basis depending upon the tier into which an AHCCCS inpatient hospital day of care is assigned.

**Historical Note**
Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3).

**R9-22-108. Repealed**

**Historical Note**
Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-109. Quality Control Related Definitions**

"Active case" means an individual or family case determined eligible for AHCCCS medical coverage.

"Annual assessment period" means the 12 month period, October 1 through September 30, and includes two six month

sample periods (October through March and April through September).

"Annual assessment period report" means the Administration's report containing the annual error rates for the Random Sample, Target Sample, and Negative Case Action Sample.

"Case" means an individual or family determined eligible or ineligible for AHCCCS medical coverage.

"Case record" means an individual or family file retained by the Department which contains all pertinent eligibility information, including electronically stored data.

"Case review" means the Administration's evaluation of an individual's or family's circumstances and case record in a review month to determine if an individual or family is eligible based on the actual circumstances verified for the action taken in a review month for AHCCCS.

"Corrective action plan" means a effective plan developed by the Department to reduce the Department's error rate when an error rate exceeds a tolerance level.

"District" means the Department's management unit based on geographical location that administers the eligibility programs.

"Error" means a review finding in which one or more members is found to be factually ineligible, approved for a program with more services under Title XIX than an applicant or member is entitled to, or discontinued or denied when a member is factually eligible in a review month. An error may include misclassification resulting in additional expenses or liability to the Administration or loss of AHCCCS medical coverage for the applicant or member.

"Finding" means a result based on the Administration's review.

"Management evaluation review" means the process by which the Administration determines whether the Department meets specific performance measures.

"Notice of Findings" means a report provided to the Department by the Administration when a review is completed.

"Performance measures" means the methods by which the Administration determines the extent to which the Department meets the pre-determined standards and goals.

"Preponderance of evidence" means the greater weight of evidence.

"Random sample" means a representative population with each case having an equal chance of being chosen, having no specific pattern, purpose, organization, or structure other than as defined by case characteristic.

"Review period" means the April through September and October through March time periods that the Administration selects and completes a review of case records.

"Summary report" means the Administration's report issued at the end of each six month review period summarizing all review findings including eligibility errors, technical errors, administrative deficiencies, and corrective action requirements.

"Tolerance level" means the percentage of errors which the Administration accepts.

**Historical Note**
Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-110. Repealed**

**Historical Note**
Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

**R9-22-111. Reserved**

**R9-22-112. Behavioral Health Services Related Definitions**
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"ADHS" means the Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona residents.

"Behavior management services" means those services that assist the member in carrying out daily living tasks and other activities essential for living in the community.

"Behavioral health evaluation" means the assessment of a member's medical, psychological, psychiatric, or social condition to determine if a behavioral health disorder exists and, if so, to establish a treatment plan for all medically necessary services.

"Behavioral health medical practitioner" means a health care practitioner with at least one year of full-time behavioral health work experience.

"Behavioral health professional" defined in 9 A.A.C. 20.

"Behavioral health service" means those services provided for the evaluation and diagnosis of a mental health or substance abuse condition, and the planned care, treatment, and rehabilitation of the member.

"Behavioral health technician" defined in 9 A.A.C. 20.

"Board-eligible for psychiatry" means completion of an accredited psychiatry residency program approved by the American College of Graduate Medical Education, or the American Osteopathic Association. Documentation of completion of a residency program includes a certificate of residency training including exact dates of residency, or a letter of verification of residency training from the training director including the exact dates of training period.

"Certified psychiatric nurse practitioner" under A.R.S. § 32-1601 and certified under the American Nursing Association's Statement and Standards for Psychiatric-Mental Health Clinical Nursing Practice under A.A.C. R4-19-505.

"Clinical supervision" means a review of skills and knowledge and guidance in improving or developing skills and knowledge provided by a Clinical Supervisor under 9 A.A.C. 20, Article 2.

"De novo hearing" defined in 42 CFR 431.201.

"Health care practitioner" means a:

Physician;

Physician assistant;

Nurse practitioner; or

Other individual licensed and authorized by law to use and prescribe medication and devices, as defined in A.R.S. § 32-1901.

"IMD" means an Institution for Mental Diseases as described in 42 CFR 435.1009 and licensed by ADHS.

"Mental disorder" defined in A.R.S. § 36-501.

"Partial Care" means a day program of services provided to individual members or groups designed to improve the ability of a person to function in the community.

"Psychiatrist" under A.R.S. §§ 32-1401 or 32-1800 and 36-501.

"Psychologist" under A.R.S. §§ 32-2061 and 36-501.

"Psychosocial rehabilitation services" mean those services that include the provision of education, coaching, training, and demonstration to remediate residual or prevent anticipated functional deficits and may include services that may assist a member to secure and maintain employment. Psychosocial rehabilitation services may include:

Living skills training,

Cognitive rehabilitation,

Health promotion,

Supported employment, and

Other services which increase social and communication skills in order to maximize a member's ability to participate in the community and function independently.

"RBHA" means the Regional Behavioral Health Authority defined in A.R.S. § 36-3401.

**Historical Note**
Adopted effective December 8, 1997 (Supp. 97-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-113. Reserved**

**R9-22-114. AHCCCS Medical Coverage for Families and Individuals Related Definitions**

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Act" means the Social Security Act.

"Adverse action" means an action taken by the Department to deny, discontinue, or reduce medical assistance.

"Appellant" means an applicant or member who is appealing an adverse action by the Department.

"Authorized representative" means a person who is authorized to apply or act on behalf of another person.

"Baby Arizona" means the public or private partnership program that provides a pregnant woman an opportunity to apply for AHCCCS medical coverage at a Baby Arizona provider's office through a streamlined eligibility process.

"BHS" means Behavioral Health Services, Arizona Department of Health Services.

"Burial plot" means a space reserved in a cemetery, crypt, vault, or mausoleum for the remains of a deceased person.

"Caretaker relative" means a parent or other specified relative who maintains a family setting for a dependent child and who exercises responsibility for the day-to-day physical care, guidance, and support of that child.

"Cash assistance" means a program administered by the Department that provides assistance to needy families with dependent children under 42 U.S.C. 601 et seq.

"CRS" means ADHS Children's Rehabilitation Services.

"DCSE" means the Division of Child Support Enforcement, which is the division within the Department that administers the Title IV-D program and includes a contract agent operating a child support enforcement program on behalf of the Department.

"Dependent child" means a child defined in A.R.S. § 46-101.

"FAA" means the Family Assistance Administration, the administration within the Department's Division of Benefits and Medical Eligibility with responsibility for providing cash and food stamp assistance to a member and for determining eligibility for AHCCCS medical coverage.

"Foster care maintenance payment" means a monetary amount defined in 42 U.S.C. 675(4)(A).

"Homebound" means a person who is confined to home because of physical or mental incapacity.

"Income" means combined earned and unearned income.

"Mailing date," when used in reference to a document sent first class, postage prepaid, through the United States mail, means the date:

Shown on the postmark;

Shown on the postage meter mark of the envelope, if no postmark; or

Entered on the document as the date of its completion, if no legible postmark or postage meter mark or if the mark is illegible.

"Medical expense deduction" means the cost of:

A medical service or supply that would be covered if provided to an AHCCCS member of any age under 9 A.A.C. 22, Articles 2 and 12;

A medical service or supply that would be covered if provided to an ALTCS member under 9 A.A.C. 28, Articles 2 and 11;

Other necessary medical services provided by a licensed practitioner or physician;

Assistance with daily living provided the assistance is documented in an individual plan of care except when provided by the spouse of a applicant or the parent of a minor child;

Medical services provided in a licensed nursing home, supervisory care facility, adult foster home, or in another residential care facility licensed by the Arizona Department of Health Services;

Purchasing and maintaining animal guide or service animal for the assistance of the member of the MED family unit; or

Health insurance premiums, deductibles, and coinsurance, if the insured is a member of the MED family unit.

"Medical support" means an obligation of a natural or adoptive parent to provide health care coverage in the form of health insurance or court-ordered payment for medical care.

"Nonparent caretaker relative" means a person, other than a parent, who is related by blood, marriage, or lawful adoption to the dependent child and who:

Maintains a family setting for the dependent child; and

Exercises responsibility for the day-to-day care of the dependent child.

"Pre-enrollment process" means the process that provides an applicant the opportunity to choose an AHCCCS health plan before the determination of eligibility is completed.

"Resources" means real and personal property, including liquid assets.

"Review" means a review of all factors affecting an unit's a family's eligibility.

"Specified relative" natural or adoptive parent or a stepparent and any other nonparent relative related by blood or adoption including a spouse of these persons even if death or divorce terminates the marriage. Specified relative may include:

Grandmother;

Grandfather;

Brother;

Sister;

Uncle;

Aunt;

First cousin;

Nephew;

Niece;

Persons of preceding generations as denoted by prefixes grand or great, or to the fifth degree grandparent; and

First cousins once removed.

"Spendthrift restriction" means a legal restriction on the use of a resource that prevents a payee or beneficiary from alienating the resource.

"SVES" means the State Verification and Exchange System, a system through which the Department exchanges income and benefit information with the Internal Revenue Service, Social Security Administration, State Wage, and Unemployment Insurance Benefit data files.

"Title IV-D" of the Social Security Act means 42 U.S.C. 651-669, the statutes establishing the child support enforcement and establishment of paternity program.

"Title IV-E" of the Social Security Act means 42 U.S.C. 670-679, the statutes establishing the foster care and adoption assistance programs.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-115. AHCCCS Medical Coverage for People Who Are Aged, Blind, or Disabled Related Definitions**
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Aged" means a person who is 65 years of age or older, specified in 42 U.S.C. 1382c(a)(1)(A).

"Blind" means a person who has been determined blind by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(2).

"Disabled" means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E).

**Historical Note**
Final Section adopted at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-116. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-117. Enrollment Related Definitions**
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Annual enrollment choice" means the annual opportunity for a person to change contractors.

"Auto-assignment algorithm" means the mathematical formula used by the Administration to assign persons to the various contractors.

"CMDP" means Comprehensive Medical and Dental Program.

"Disenrollment" means the discontinuance of a person's entitlement to receive covered services from a contractor of record.

"Enrollment" means the process by which an eligible person becomes a member of a contractor's plan.

"IHS" means Indian Health Service.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-120. Breast and Cervical Cancer Treatment Program Related Definitions**
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meaning unless the context explicitly requires another meaning:

"Cryotherapy" means the destruction of abnormal tissue using an extremely cold temperature.

"LEEP" means the loop electrosurgical excision procedure that passes an electric current through a thin wire loop.

"Peer-reviewed study" means that, prior to publication, a medical study has been subjected to the review of medical experts who:

Have expertise in the subject matter of the study,

Evaluate the science and methodology of the study,

Are selected by the editorial staff of the publication, and

Review the study without knowledge of the identity or qualifications of the author.

"WWHP" means the Well Women Healthcheck Program administered by the Arizona Department of Health Services.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4).

## ARTICLE 2. SCOPE OF SERVICES

### R9-22-201. General Requirements

**A.** For the purposes of this Article,
1. Authorization means written or verbal authorization by:
   a. The Administration for services rendered to a fee-for-service member, and or
   b. The contractor for services rendered to a prepaid capitated member.
2. Use of the phrase "attending physician" applies only to the fee-for-service population.

**B.** In addition to requirements and limitations specified in this Chapter, the following general requirements apply:
1. Only medically necessary, cost effective, and federally and state reimbursable services are covered services;
2. Covered services for the state and federal emergency services programs (FESP and SESP) are under R9-22-217;
3. The Administration or a contractor may waive the covered services referral requirements required by this Article;
4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner shall not diminish the role or responsibility of the primary care provider;
5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider;
6. A member may receive behavioral health evaluation services without a referral from a primary care provider. A member may receive behavioral health treatment services only under referral from and in consultation with the primary care provider, or upon authorization by the contractor or its designee;
7. A member may receive a treatment that is considered the standard of care, or that is approved by AHCCCS Chief Medical Officer after appropriate consultative input from providers who are considered experts in the field by the professional medical community;
8. A member shall receive services according to the Section 1115 Waiver as defined in A.R.S. § 36-2901;
9. An AHCCCS registered provider shall provide covered services within the provider's scope of practice;
10. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
    a. A service that is determined by the Chief Medical Officer to be experimental or provided primarily for the purpose of research;
    b. Services or items furnished gratuitously; and
    c. Personal care items; and
11. Medical or behavioral health services are not covered services if provided to:
    a. An inmate of a public institution;
    b. A person who is in residence at an institution for the treatment of tuberculosis; or
    c. A person age 21 through 64 who is in an IMD, unless provided under Article 12 of this Chapter.

**C.** The Administration or contractor may deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. Documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.

**D.** Services under A.R.S. § 36-2908 provided during the prior period coverage do not require prior authorization.

**E.** Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. Diagnostic and treatment procedures for a condition that is unrelated to the emergency medical condition require prior authorization by the Administration or contractor.

**F.** A member shall receive covered services outside the contractor's service area only if one of the following apply:
1. A member is referred by a primary care provider for medical specialty care out of the contractor's area. If a member is referred out of the contractor's service area to receive an authorized medically necessary service, a contractor shall also provide all other medically necessary covered services for the member.
2. There is a net savings in service delivery costs as a result of going outside the service area that does not require undue travel time or hardship for a member or the member's family;
3. The contractor authorizes placement in a nursing facility located out of the contractor's service area; or
4. Services are provided during the prior period coverage time-frame.

**G.** If a member is traveling or temporarily residing out of the member's contractor service area, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

**H.** A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Article, Chapter, and in contract.

**I.** The Administration shall determine the circumstances under which a FFS member may receive services, other than emergency services, from service providers outside the member's county of residence or outside the state. Criteria considered by the Administration in making this determination shall include availability and accessibility of appropriate care, and cost effectiveness.

**J.** If a member requests the provision of a service that is not covered or not authorized by a contractor or the Administration, an AHCCCS registered provider may render the service and request reimbursement from the member if:
1. The provider prepares and provides the member with a document that lists the requested services and the estimated cost of each service, and
2. The member signs the document prior to the provision of services indicating that the member understands and accepts the responsibility for payment.

**K.** The restrictions, limitations, and exclusions in this Article do not apply to the following groups:
1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27, and benefits not covered by AHCCCS; and
2. A contractor electing to provide noncovered services.

a. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
b. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-201 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

**R9-22-202. Repealed**

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-202 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Amended effective July 1, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1994, Ch. 322, § 21; filed with the Office of the Secretary of State June 22, 1995 (Supp. 95-3). Amended effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Section repealed effective September 22, 1997 (Supp. 97-3).

**R9-22-203. Repealed**

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-203 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed effective September 22, 1997 (Supp. 97-3).

**R9-22-204. Inpatient General Hospital Services**

**A.** A contractor, fee-for-service provider or noncontracting provider shall render inpatient general hospital services including:
1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
   a. Maternity care, including labor, delivery, and recovery room, birthing center, and newborn nursery;
   b. Neonatal intensive care unit (NICU);
   c. Intensive care unit (ICU);
   d. Surgery, including surgery room and recovery room;
   e. Nursery and related services;
   f. Routine care; and
   g. Emergency behavioral health services provided under Article 12 of this Chapter for a member eligible under A.R.S. § 36-2901(6)(a).
2. Ancillary services as specified by the Director and included in contract:
   a. Laboratory services;
   b. Radiological and medical imaging services;
   c. Anesthesiology services;
   d. Rehabilitation services;
   e. Pharmaceutical services and prescription drugs;
   f. Respiratory therapy;
   g. Blood and blood derivatives; and
   h. Central supply items, appliances, and equipment that are not ordinarily furnished to all patients and customarily reimbursed as ancillary services.

**B.** The following limitations apply to inpatient general hospital services that are provided by FFS providers.
1. Providers shall obtain prior authorization from the Administration for the following inpatient hospital services:
   a. Nonemergency and elective admission, including psychiatric hospitalization;
   b. Elective surgery, excluding a voluntary sterilization procedure. Voluntary sterilization procedure does not require prior authorization; and
   c. Services or items provided to cosmetically reconstruct or improve personal appearance after an illness or injury.
2. The Administration may perform concurrent review for hospitalizations to determine whether there is medical necessity for the hospitalization.
   a. A provider shall notify the Administration no later than the fourth day of hospitalization after an emergency admission or no later than the second day after an intensive care unit admission so that the Administration may initiate concurrent review of the hospitalization.
   b. Failure of the provider to obtain prior authorization is cause for denial of a claim.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-204 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective December 22, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

**R9-22-205. Attending Physician, Practitioner, and Primary Care Provider Services**

**A.** A primary care provider, attending physician, or practitioner shall provide primary care provider services within the provider's scope of practice under A.R.S. Title 32. A member may receive primary care provider services in an inpatient or outpatient setting including at a minimum:
1. Periodic health examination and assessment;
2. Evaluation and diagnostic workup;
3. Medically necessary treatment;
4. Prescriptions for medication and medically necessary supplies and equipment;
5. Referral to a specialist or other health care professional if medically necessary;
6. Patient education;
7. Home visits if medically necessary;
8. Covered immunizations; and
9. Covered preventive health services.

**B.** The following limitations and exclusions apply to attending physician and practitioner services and primary care provider services:
1. Specialty care and other services provided to a member upon referral from a primary care provider, or to a member upon referral from the attending physician or practitioner are limited to the service or condition for which the referral is made, or for which authorization is given by the Administration or a contractor.
2. A member's physical examination is not covered if the sole purpose is to obtain documentation for one or more of the following:
   a. Qualification for insurance;
   b. Pre-employment physical evaluation;
   c. Qualification for sports or physical exercise activities;
   d. Pilot's examination for the Federal Aviation Administration;
   e. Disability certification to establish any kind of periodic payments;
   f. Evaluation to establish third-party liabilities; or
   g. Physical ability to perform functions that have no relationship to primary objectives of the services listed in subsection (A).
3. Orthognathic surgery is covered only for a member who is less than 21 years of age;
4. The following services are excluded from AHCCCS coverage:
   a. Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgeries;
   b. Pregnancy termination counseling services;
   c. For federally funded programs, pregnancy terminations, unless required by federal law.
   d. For the state emergency services programs (SESP), pregnancy terminations that are not permitted by state law.
   e. Services or items furnished solely for cosmetic purposes; and
   f. Hysterectomies unless determined medically necessary.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-205 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A), paragraph (15) and added paragraph (20) effective December 22, 1987 (Supp. 87-4). Amended subsection (C)(2) effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

***Editor's Note: The following Section was renumbered and a new Section adopted under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not published as a proposed rule in the Arizona Administrative Register; the rule was not reviewed or approved by the Governor's Regulatory Review Council; and the agency was not required to hold public hearings on the rule. This Section was subsequently amended through the regular rulemaking process.***

**R9-22-206. Organ and Tissue Transplant Services**

**A.** Under A.R.S. § 36-2907, organ and tissue transplant services are covered for a member if prior authorized and coordinated with the member's contractor, or the Administration.

**B.** Organ and tissue transplant services are not covered for qualified aliens or noncitizens members of FESP under A.R.S. § 36-2903.03(D) or members of SESP under A.R.S. § 36-2901.06.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-206 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-206 renumbered to R9-22-218, new Section R9-22-206 adopted effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4).

**R9-22-207. Dental Services**

**A.** The Administration or a contractor shall cover dental services for a member less than 21 years of age under R9-22-213.

**B.** The Administration or a contractor shall cover the following emergency dental care services:
1. Oral diagnostic examination including laboratory and radiographs if necessary to determine an emergency medical condition;
2. Immediate and palliative procedures, including extractions if medically necessary, for relief of severe pain associated with an oral or maxillofacial condition;
3. Initial treatment for acute infection;
4. Immediate and palliative procedures for acute craniomandibular problems and for traumatic injuries to teeth, bone, or soft tissue;

5. Preoperative procedures; and
6. Anesthesia appropriate for optimal patient management.

**C.** Covered denture services are medically necessary dental services and procedures associated with, and including, the provision of dentures.

**D.** The following limitations apply to dentures:
1. Provision of dentures for cosmetic purposes is not a covered service;
2. Extractions of asymptomatic teeth are not covered unless their removal is the most cost-effective dental procedure for the provision of dentures; and
3. Radiographs are covered only if used as a diagnostic tool preceding treatment of symptomatic teeth and to support the need for, and provision of, dentures.

**E.** The following limitations apply to emergency dental services provided by the Administration's fee-for-service providers for a member age 21 or older:
1. Treatment for the prevention of pulpal death and imminent tooth loss is covered only for non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection. Root canals are covered only to treat active infection or to eliminate pain;
2. Routine restorative procedures and routine root canal therapy are not emergency services and are not covered;
3. Radiographs are covered only for symptomatic teeth for use as a diagnostic tool preceding treatment and to support the need for, and provision of, dentures;
4. Maxillofacial dental services provided by a dentist are not covered unless prescribed for the reduction of trauma, including reconstruction of regions of the maxillae and mandible; and
5. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.

**F.** Prior authorization of dental services for a FFS member is required from the Administration for the following:
1. Provision of medically necessary dentures;
2. Replacement, repair, or adjustment to dentures; and
3. Provision of obturators or other prosthetic appliances for restoration or rehabilitation.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-207 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-207 repealed, new Section R9-22-207 adopted effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

**R9-22-208. Laboratory, Radiology, and Medical Imaging Services**

Laboratory, radiology, and medical imaging services are covered services if:
1. Prescribed by the member's attending physician, practitioner, primary care provider or a dentist, or prescribed by a physician or practitioner upon referral from the primary care provider or dentist.
2. Provided by licensed health care providers in a:
   a. Hospital,
   b. Clinic,
   c. Physician's office, or
   d. Other health care facility.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-208 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-208 repealed, new Section R9-22-208 adopted effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

**R9-22-209. Pharmaceutical Services**

**A.** An inpatient or outpatient provider, including a hospital, clinic, other appropriately licensed health care facility, and pharmacy may provide covered pharmaceutical services.

**B.** The Administration or a contractor shall require a provider to make pharmaceutical services:
1. Available during customary business hours, and
2. Located within reasonable travel distance of a member's residence.

**C.** Pharmaceutical services are covered if:
1. Prescribed for a member by the member's primary care provider, attending physician, practitioner, or dentist;
2. Prescribed by a specialist upon referral from the primary care provider or attending physician; or
3. The contractor or its designee authorizes the service.

**D.** The following limitations apply to pharmaceutical services:
1. A medication personally dispensed by a physician, dentist, or a practitioner within the individual's scope of practice is not covered, except in geographically remote areas where there is no participating pharmacy or if accessible pharmacies are closed.
2. A prescription or refill in excess of 100-unit doses is not covered. A prescription or refill in excess of a 30 day supply is not covered unless specified in subsection (D)(3).
3. A prescription or refill in excess of a 30-day supply is covered if:
   a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit doses, whichever is greater.
   b. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 day supply or 100-unit doses, whichever is greater.
   c. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.
4. An over-the-counter medication, in place of a covered prescription medication, is covered only if the over-the-counter medication is appropriate, equally effective, safe, and less costly than the covered prescription medication.

**E.** A contractor shall monitor and ensure sufficient services to prevent any gap in the pharmaceutical regimen of a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well being.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-209 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective Octo-

ber 1, 1985 (Supp. 85-5). Amended effective September 24, 1986 (Supp. 86-5). Amended subsections (A) and (C) effective December 22, 1987 (Supp. 87-4). Amended subsection (C)(3), effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

**R9-22-210. Emergency Medical and Behavioral Health Services**

**A.** For members enrolled with a contractor, AHCCCS contractors shall reimburse providers for emergency services as defined by and to the extent required by 42 U.S.C. 1396u-2.

**B.** Verification. A provider of emergency services shall verify a member's eligibility and enrollment status through the Administration to determine the need for notification to a contractor for a member, or the Administration for a FFS member, and to determine the party responsible for payment of services rendered.

**C.** Access. A contractor shall ensure access to an emergency room and emergency medical or behavioral health services, which are available 24 hours per day, seven days per week in each contractor's service area. A contractor shall ensure that the use of an examining or a treatment room is available if required by a physician or a practitioner for the provision of emergency services.

**D.** Behavioral health evaluation. A behavioral health evaluation provided by a psychiatrist or a psychologist is covered as an emergency service under this Section if required to evaluate or stabilize an acute episode of mental disorder or substance abuse.

**E.** Prior authorization. An emergency service does not require prior authorization; however, a provider shall comply with the following notification requirements to a contractor:

1. A provider and a noncontracting provider furnishing emergency services to a member shall notify a member's contractor within 12 hours from the time a member presents for services;
2. If a member's medical condition is determined by the provider not to be an emergency medical condition, a provider shall:
   a. Notify the member's contractor before initiation of treatment; and
   b. Follow the prior authorization requirements and protocol of the contractor regarding treatment of the member's nonemergency medical condition. Failure of the provider to obtain prior authorization is cause for denial.

**F.** Post-stabilization services. After a member's emergency medical condition is stabilized, a provider or a noncontracting provider shall request authorization from the contractor for post-stabilization services under 42 U.S.C. 1396u-2.

**G.** A provider of emergency services for a FFS member is not required to notify the Administration.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-210 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-210 repealed, new Section R9-22-210 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (1) effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

**R9-22-211. Transportation Services**

**A.** Emergency ambulance services.

1. A member shall receive medically necessary emergency transportation in a ground or air ambulance:
   a. To the nearest appropriate provider or medical facility capable of meeting the member's medical needs; and
   b. If no other appropriate means of transportation is available.
2. The Administration or a member's contractor shall reimburse a ground or air ambulance transport that originates in response to a 911 call or other emergency response system:
   a. If the member's medical condition justifies the medical necessity of the type of ambulance transportation received,
   b. The transport is to the nearest appropriate provider or medical facility capable of meeting the member's medical needs, and
   c. No prior authorization is required for reimbursement of these transports.
3. The member's medical condition at the time of transport determines whether the transport is medically necessary.
4. A ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure of the provider to obtain prior authorization is cause for denial.
5. Notification to the Administration of emergency transportation provided to a FFS member is not required, but the provider shall submit documentation with the claim which justifies the service.

**B.** The Administration or a contractor covers air ambulance services only if one or more of the criteria in subsection (B)(1), (2), or (3) is met. The criteria are:

1. The air ambulance transport is initiated at the request of:
   a. An emergency response unit;
   b. A law enforcement official;
   c. A clinic or hospital medical staff member; or
   d. A physician or practitioner; and
2. The point of pickup:
   a. Is inaccessible by ground ambulance; or
   b. Is a great distance from the nearest hospital or other provider with appropriate facilities to treat the member's condition; or
3. The medical condition of the member requires immediate:
   a. Intervention from emergency ambulance personnel or providers with the appropriate facilities to treat the member's condition, or
   b. Ground ambulance service will not suffice for the factors listed in subsection (B)(2).

**C.** Medically necessary nonemergency transportation is limited to the cost of transporting the member to an appropriate provider capable of meeting the member's medical needs.
1. As specified in contract, a contractor shall arrange or provide medically necessary nonemergency transportation services for a member who is unable to arrange transportation to a service site or location.
2. For a fee-for-service member, the Administration shall authorize medically necessary nonemergency transportation for a member who is unable to arrange transportation to a service site or location.

**D.** For the purposes of this subsection, an individual means a person who is not in the business of providing transportation services such as a family or household member, friend, or neighbor. The Administration or a contractor shall cover expenses for transportation in traveling to and returning from an approved and prior authorized health care service site provided by an individual if:
1. The transportation services are authorized by the Administration or the member's contractor or designee;
2. The individual is an AHCCCS registered provider; and
3. No other means of appropriate transportation is available.

**E.** The Administration or a contractor shall cover expenses for meals, lodging, and transportation for a member traveling to and returning from an approved and prior authorized health care service site outside of the member's service area or county of residence.

**F.** The Administration or a contractor shall cover the expense of meals, lodging, and transportation for:
1. A family member accompanying a member if:
   a. The member is traveling to or returning from an approved and prior authorized health care service site outside of the member's service area or county of residence; and
   b. The meals, lodging, and transportation services are authorized by the Administration or the member's contractor or designee.
2. An escort who is not a family member as follows:
   a. If the member is travelling to or returning from an approved and prior authorized health care service site, including an inpatient facility, outside of the member's service area or county of residence; and
   b. If the escort services are authorized by the Administration or the member's contractor or designee.
   c. Wage paid to an escort as reimbursement shall not exceed the federal minimum wage.

**G.** A provider shall obtain prior authorization from the Administration for transportation services provided for a member for the following:
1. Medically necessary nonemergency transportation services not originated through a 911 call or other emergency response system; and
2. All meals, lodging, and services of an escort accompanying the member under this Section.

**H.** A charitable organization routinely providing transportation service at no cost to an ambulatory or chairbound person shall not charge or seek reimbursement from the Administration or a contractor for the provision of the service to a member but may enter into a subcontract with a contractor for medically necessary transportation services provided to a member.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-211 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

**R9-22-212. Medical Supplies, Durable Medical Equipment, and Orthotic and Prosthetic Devices**

**A.** Medical supplies, durable medical equipment, and orthotic and prosthetic devices are covered services if provided in compliance with requirements of this Chapter, and
1. Prescribed by the primary care provider, attending physician, practitioner, or dentist;
2. Prescribed by a specialist, upon referral from the primary care provider; attending physician, practitioner or dentist; and
3. Authorized as required by the Administration, contractor, or contractor's designee.

**B.** Covered medical supplies are consumable items that are disposable and are essential for the member's health.

**C.** Covered DME is any item, appliance, or piece of equipment that is:
1. Designed for a medical purpose,
2. To withstand wear,
3. Generally reusable by others, and
4. Purchased or rented for a member.

**D.** Covered prosthetic and orthotic devices are only those items that are essential for the habilitation or rehabilitation of a member.

**E.** The following limitations on coverage apply:
1. The DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the DME does not exceed the cost of the DME if purchased.
2. Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.
3. A change in, or addition to, an original order for DME is covered if approved by the member's primary care provider or authorized prescriber, or prior authorized by the Administration or contractor, and the change or addition is indicated clearly on the order and initialed by the vendor. No change or addition to the original order for DME may be made after a claim for services is submitted to the member's contractor, or the Administration, without prior written notification of the change or addition.
4. Reimbursement for rental fees shall terminate:
   a. No later than the end of the month in which the primary care provider or authorized prescriber certifies that the member no longer needs the DME;
   b. If the member is no longer eligible for AHCCCS services; or
   c. If the member is no longer enrolled with a contractor, with the exception of transitions of care as specified by the Administration.
5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition and:
   a. Prescribed by:
      i. The member's primary care provider, attending physician, practitioner;
      ii. A specialist upon referral from the primary care provider, attending physician, or practitioner; and

b. Authorized as required by the Administration, or contractor or its designee.

6. First aid supplies are not covered unless they are provided in accordance with a prescription.
7. Hearing aids are not covered for a member who is age 21 or older.
8. Prescriptive lenses are not covered for a member who is age 21 or older unless they are the sole visual prosthetic device used by the member after a cataract extraction.

**F.** Liability and ownership.

1. Purchased DME provided to a member that is no longer needed may be disposed of in accordance with each contractor's policy.
2. The Administration shall retain title to purchased DME supplied to a member who becomes ineligible or no longer requires its use.
3. If customized DME is purchased by the Administration or contractor for a member, the equipment shall remain with the person during times of transition, or upon loss of eligibility.
   a. For purposes of this Section, customized DME refers to equipment that is altered or built to specifications unique to a member's medical needs and that, most likely, cannot be used or reused to meet the needs of another individual.
   b. A member shall return customized DME obtained fraudulently to the Administration or the contractor.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-212 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-212 repealed, new Section R9-22-212 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (2), and deleted subsection (C) effective October 1, 1986 (Supp. 86-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

**R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)**

**A.** The following E.P.S.D.T. services are covered for a member less than 21 years of age:

1. Screening services including:
   a. Comprehensive health and developmental history;
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations according to age and health history;
   d. Laboratory tests; and
   e. Health education, including anticipatory guidance;
2. Vision services including:
   a. Diagnosis and treatment for defects in vision;
   b. Eye examinations for the provision of prescriptive lenses; and
   c. Provision of prescriptive lenses;
3. Hearing services including:
   a. Diagnosis and treatment for defects in hearing;
   b. Testing to determine hearing impairment; and
   c. Provision of hearing aids;
4. Dental services including:
   a. Emergency dental services as specified in R9-22-207;
   b. Preventive services including screening, diagnosis, and treatment of dental disease; and
   c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
5. Orthognathic surgery;
6. Nutritional assessment and nutritional therapy as specified in contract to provide complete daily dietary requirements or supplement a member's daily nutritional and caloric intake;
7. Behavioral health services under 9 A.A.C. 22, Article 12;
8. Hospice services as follows:
   a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within six months;
   b. Services available to a member receiving hospice care are limited to those allowable under 42 CFR 418.202, December 20, 1994, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments; and
   c. Hospice services do not include:
      i. Medical services provided that are not related to the terminal illness; or
      ii. Home delivered meals.
   d. Hospice services that are provided and covered through Medicare are not covered by AHCCCS.
9. Other necessary health care, diagnostic services, treatment, and measures required by 42 U.S.C. 1396d(r)(5).

**B.** Providers of E.P.S.D.T. services shall meet the following standards:

1. Provide services by or under the direction of the member's primary care provider, attending physician, practitioner, or dentist.
2. Perform tests and examinations under 42 CFR 441 Subpart B, January 29, 1985, which is incorporated by reference and on file with the Office of the Secretary of State and the Administration. This incorporation by reference contains no future editions or amendments.
3. Refer a member as necessary for dental diagnosis and treatment and necessary specialty care.
4. Refer a member as necessary for behavioral health evaluation and treatment services.

**C.** Contractors shall meet other E.P.S.D.T. requirements as specified in contract.

**D.** A primary care provider, attending physician, or practitioner shall refer a member with special health care needs under R9-7-301 to CRS.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-213 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-213 repealed, new Section R9-22-213 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

**R9-22-214. Repealed**

**Historical Note**
Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-214 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-214 repealed, new Section R9-22-214 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (4) and added subsection (C), paragraph (2) effective October 1, 1986 (Supp. 86-5). Correction to subsection (C), paragraph (2) (Supp. 87-4). Section repealed effective September 22, 1997 (Supp. 97-3).

**R9-22-215. Other Medical Professional Services**

**A.** The following medical professional services are covered services if a member receives these services in an inpatient, outpatient, or office setting as follows:
1. Dialysis;
2. The following family planning services if provided to delay or prevent pregnancy:
   a. Medications;
   b. Supplies;
   c. Devices; and
   d. Surgical procedures.
3. Family planning services are limited to:
   a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
   b. Sterilization; and
   c. Natural family planning education or referral;
4. Midwifery services provided by a certified nurse practitioner in midwifery;
5. Midwifery services for low-risk pregnancies and home deliveries provided by a licensed midwife;
6. Podiatry services when ordered by a member's primary care provider, attending physician, or practitioner;
7. Respiratory therapy;
8. Ambulatory and outpatient surgery facilities services;
9. Home health services under A.R.S. § 36-2907(D);
10. Private or special duty nursing services when medically necessary and prior authorized;
11. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology within limitations in subsection (C);
12. Total parenteral nutrition services, which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract;
13. Inpatient chemotherapy; and
14. Outpatient chemotherapy.

**B.** Prior authorization from the Administration for a member is required for services listed in subsections (A)(4) through (12).

**C.** The following services are excluded as covered services:
1. Occupational and speech therapies provided on an outpatient basis for a member age 21 or older;
2. Physical therapy provided only as a maintenance regimen;
3. Abortion counseling; or
4. Services or items furnished solely for cosmetic purposes.

**Historical Note**
Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-215 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

**R9-22-216. NF, Alternative HCBS Setting, or HCBS**

**A.** Services provided in a NF, alternative HCBS setting as defined in R9-28-101, or HCBS as defined in R9-28-101 are covered for a maximum of 90 days per contract year if the member's medical condition would otherwise require hospitalization.

**B.** Except as otherwise provided in 9 A.A.C. 28, the following services are not itemized for separate billing if provided in a NF, alternative HCBS setting, or HCBS:
1. Nursing services including:
   a. Administering medication,
   b. Tube feedings,
   c. Personal care service (assistance with bathing and grooming),
   d. Routine testing of vital signs, and
   e. Maintenance of catheter;
2. Basic patient care equipment and sickroom supplies including:
   a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over-the-counter remedies;
   b. Bathing and grooming supplies;
   c. Identification device;
   d. Skin lotion;
   e. Medication cup;
   f. Alcohol wipes, cotton balls, and cotton rolls;
   g. Rubber gloves (non-sterile);
   h. Laxatives;
   i. Bed and accessories;
   j. Thermometer;
   k. Ice bags;
   l. Rubber sheeting;
   m. Passive restraints;
   n. Glycerin swabs;
   o. Facial tissue;
   p. Enemas;
   q. Heating pad;
   r. Diapers; and
   s. Alcoholic beverages;
3. Dietary services including preparation and administration of special diets, and adaptive tools for eating;
4. Any service that is included in a NF's room and board charge or a service that is required of the NF to meet a federal, state licensure standard, or county certification requirement;
5. Physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
6. Physical therapy prescribed only as a maintenance regimen; and
7. Assistive devices or non-customized durable medical equipment.

**C.** A provider shall obtain prior authorization from the Administration for a NF admission for a FFS member.

**Historical Note**
Adopted effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Sub-

section (C) amended to correct a typographical error (Supp. 00-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

***Editor's Note: The following Section was adopted and amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. This Section was subsequently repealed and a new Section adopted under the regular rulemaking process.***

**R9-22-217. Services Included in the State and Federal Emergency Services Programs**

**A.** General. For the purposes of this Section, emergency medical condition means a person in the SESP or FESP program is limited to services necessary to treat the sudden onset of a medical condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
1. Placing the patient's health in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

**B.** Services are not covered unless all of the criteria in subsection (A) are met at the time the service is rendered. An emergency medical condition shall be determined on a case-by-case basis.

**Historical Note**

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4).

**R9-22-218. Repealed**

**Historical Note**

Section R9-22-218 renumbered from R9-22-206 effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Section repealed effective September 22, 1997 (Supp. 97-3).

## ARTICLE 3. REPEALED

**R9-22-301. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-301 renumbered together with former Section R9-22-102 as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). New Section R9-22-301 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (8), subsection (E), paragraph (3), and subsection (J), paragraph (5) effective October 1, 1986 (Supp. 86-5). Amended subsections (C) and (E) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B) and (C) effective October 1, 1987; amended subsection (D) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-302. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-302 repealed, new Section R9-22-302 adopted effective November 20, 1984 (Supp. 84-6). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-303. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-303 repealed, new Section R9-22-303 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-304. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-304 repealed, new Section R9-22-304 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-305. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-305 repealed, new Section R9-22-305 adopted effective November 20, 1984 (Supp. 84-6). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-306. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-306 repealed, new Section R9-22-306 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraphs (1) and (6) effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (1) and added a new subsection (N) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective October 1, 1987; amended subsection (N) effective December 22, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the pro-

visions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-307. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsections (A) and (C), added subsection (G) and (H) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-307 repealed, new Section R9-22-307 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) as an emergency effective December 4, 1985 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 85-6). Permanent amendment to subsection (A) effective February 5, 1986 (Supp. 86-1). Amended subsections (E) and (F) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-308. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended by adding subsection (C) effective March 2, 1984 (Supp. 84-2). Former Section R9-22-308 repealed, new Section R9-22-308 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-309. Repealed**

**Historical Note**

Adopted effective August 30, 1984 (Supp. 82-4). Amended (D)(1)(d) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-309 repealed, new Section R9-22-309 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (F) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (A), (B) and (C) effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-310. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended (B)(7) and added subsections (C) and (D) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-310 repealed, new Section R9-22-310 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) and deleted subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (7) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-311. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-311 repealed, new Section R9-22-311 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-312. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsections (A) and (B), added subsection (D) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-312 repealed, new Section R9-22-312 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-313. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended subsections (C) and (D) as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended subsections (D) and (E) as an emergency effective August 16, 1984, pursuant

to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-313 repealed, new Section R9-22-313 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsections (B), (C), (E) and (G) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B) and (C) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-314. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsection (A) and added subsection (F) as an emergency effective February 28, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended subsection (A) and added subsection (F) as a permanent rule effective May 16, 1983; text of the amended rule identical to the emergency (Supp. 83-3). Former Section R9-22-314 repealed, new Section R9-22-314 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-315. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-315 repealed, new Section R9-22-315 adopted effective November 20, 1984 (Supp. 84-6). Repealed effective October 1, 1985 (Supp. 85-5). New Section R9-22-315 adopted effective February 5, 1986 (Supp. 86-1). Amended effective February 26, 1988 (Supp. 88-1). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-316. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as an emergency effective February 9, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as a permanent rule effective May 16, 1983; text of permanent rule identical to the emergency (Supp. 83-3). Amended effective October 1, 1983 (Supp. 83-5). Correction subsection (A), paragraph (1) amended effective October 1, 1983, (Supp. 83-6). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-316 repealed, new Section R9-22-316 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective October 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-317. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-317 repealed, new Section R9-22-317 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1986 (Supp. 86-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-318. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-318 repealed, new Section R9-22-318 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) and added subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective October 1, 1987; amended subsection (A) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective December 13, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-319. Repealed**

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-319 repealed, new Section R9-22-319 adopted effective November 20, 1984 (Supp. 84-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by

final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-320. Repealed**

**Historical Note**
Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-320 repealed, new Section R9-22-320 adopted effective November 20, 1984 (Supp. 84-6). Amended effective April 13, 1990 (Supp. 90-2). Repealed effective December 13, 1993 (Supp. 93-4).

**R9-22-321. Repealed**

**Historical Note**
Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-321 repealed, new Section R9-22-321 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (B) through (E) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987 (Supp. 87-4). Amended subsections (B) and (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-322. Repealed**

**Historical Note**
Adopted effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective May 27, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-3). Former Section R9-22-322 repealed, new Section R9-22-322 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-322 repealed, new Section R9-22-322 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective September 29, 1992 (Supp. 92-3). Amended December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-323. Repealed**

**Historical Note**
Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-323 repealed, new Section R9-22-323 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-323 repealed, new Section R9-22-323 adopted effective November 20, 1984 Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (B) through (D) effective October 1, 1986 (Supp. 86-5). Amended subsections (A), (B) and (D) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B), (D) and (E) effective October 1, 1987 (Supp. 87-4). Amended subsections (B) and (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-324. Repealed**

**Historical Note**
Adopted as an emergency effective July 27, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-4). Former Section R9-22-324 adopted as an emergency renumbered as Section R9-22-327. New Section R9-22-324 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-324 repealed, former Section R9-22-323 renumbered as Section R9-22-324 and adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Former Section R9-22-324 repealed, new Section R9-22-324 adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-324 repealed, new Section R9-22-324 adopted effective November 20, 1984 (Supp. 84-6). Change in heading only effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-325. Repealed**

**Historical Note**
Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-325 repealed, new Section R9-22-325 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Sup. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-326. Repealed**

**Historical Note**
Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-326 repealed, new Section R9-22-326 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Change in heading only effective October 1, 1987 (Supp. 87-4). Amended subsection (A) effective May 30, 1989 (Supp. 89-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-327. Repealed**

**Historical Note**
Former Section R9-22-324 adopted as an emergency effective July 27, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days renumbered as Section R9-22-327 and adopted as a permanent rule effective October 1, 1983 (Supp. 83-5). Former Section R9-22-327 repealed, new Section R9-22-327 adopted effective November 20,

1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (A), (D), (E), (G), (H), and (I) effective October 1, 1986 (Supp. 86-5). Amended subsection (D) and added a new subsection (J) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (A) and (E) effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-328. Repealed**

**Historical Note**

Adopted as an emergency effective October 6, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-5). Emergency Expired. New Section R9-22-328 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (A) and (E) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (D) effective October 1, 1987 (Supp. 87-4). Amended subsection (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-329. Repealed**

**Historical Note**

Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. New Section R9-22-329 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-330. Repealed**

**Historical Note**

Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. New Section R9-22-330 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended subsection (A) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-331. Repealed**

**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-332. Repealed**

**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1,1985 (Supp. 85-5). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-333. Repealed**

**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-334. Repealed**

**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-335. Repealed**

**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-336. Repealed**

**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective September 16, 1987 (Supp. 87-3). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-337. Repealed**

**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Correction to subsection (B), paragraph (1) (Supp. 87-3). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Section repealed

by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-338. Repealed**

**Historical Note**
Adopted effective November 20, 1984 (Supp. 84-6). Heading changed effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-339. Repealed**

**Historical Note**
Adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective October 1, 1987 (Supp. 87-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-340. Repealed**

**Historical Note**
Adopted effective October 1, 1986 (Supp. 86-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-341. Repealed**

**Historical Note**
Adopted effective March 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-342. Repealed**

**Historical Note**
Adopted effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-343. Repealed**

**Historical Note**
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-344. Repealed**

**Historical Note**
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

## ARTICLE 4. REPEALED

**R9-22-401. Repealed**

**Historical Note**
Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-401 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 31, 1997 (Supp. 97-1). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-402. Repealed**

**Historical Note**
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-402 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-403. Repealed**

**Historical Note**
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-403 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended by adding subsection (C) effective October 1, 1987 (Supp. 87-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-404. Repealed**

**Historical Note**
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-404 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-405. Repealed**

**Historical Note**
Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-405 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of the amended rule similar to the emergency (Supp. 83-3). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-406. Repealed**

**Historical Note**
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-406 adopted as an emergency now adopted and amended as a permanent rule effective

August 30, 1982 (Supp. 82-4). Former Section R9-22-406 repealed, new Section R9-22-406 adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as a permanent rule effective May 16, 1983; text of the Section identical to the emergency (Supp. 83-3). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

## ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

### R9-22-501. Pre-existing Conditions

**A.** Except as otherwise provided in Article 3 of this Chapter, a contractor shall be responsible for providing the full scope of covered services to each member from the effective date of eligibility until the time of notification of termination, suspension, or transfer of the member's enrollment. This responsibility includes providing treatment for all of a member's pre-existing conditions.

**B.** A contractor or subcontractor shall not adopt or use any procedure to identify individuals who have an existing or anticipated medical or psychiatric condition in order to discourage or exclude the individuals from enrolling in the contractor's health plan or encourage the individuals to enroll in another health plan.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-501 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-501 repealed, former Section R9-22-502 renumbered and adopted without change as Section R9-22-501 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-501 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

### R9-22-502. Availability and Accessibility of Service

**A.** A contractor shall provide adequate numbers of available and accessible:
1. Institutional facilities;
2. Service locations;
3. Service sites; and
4. Professional, allied, and paramedical personnel for the provision of covered services, including all emergency medical services for 24 hours a day, seven days a week.

**B.** A contractor shall minimally provide the following:
1. A ratio of primary care providers to adults and children, as specified in contract;
2. A designated emergency services facility, providing care 24 hours a day, seven days a week, accessible to members in each contracted service area. One or more physicians and one or more nurses shall be on call or on duty at the facility at all times;
3. An emergency services system employing at least one physician, registered nurse, physician's assistant, or nurse practitioner, accessible by telephone 24 hours a day, seven days a week, to members who need information in an emergency, and to providers who need verification of patient membership and treatment authorization;
4. An emergency services call log or database to track the following information:
   a. Member's name,
   b. Address and telephone number,
   c. Date and time of call,
   d. Nature of complaint or problem, and
   e. Instructions given to member.
5. A written procedure for communicating emergency services information to a member's primary care provider, and other appropriate organizational units;
6. An appointment standard as specified in contract for the following:
   a. Emergency appointments;
   b. Urgent care appointments; and
   c. Routine care appointments.
7. Waiting times for members with appointments that do not exceed 45 minutes, except when the provider is unavailable due to an emergency.

**C.** A contractor shall have an affiliation with or subcontract with an organization or individual to provide primary care services. The contractor shall agree to provide services under the primary care provider's guidance and direction.
1. A primary care provider selected by or to whom an enrolled member is assigned shall be responsible for:
   a. Supervising, coordinating, and providing initial and primary care to the member;
   b. Initiating referrals for specialty care;
   c. Maintaining continuity of member care; and
   d. Maintaining an individual medical record for each assigned member.
2. A primary care provider or specialist providing inpatient services to a member shall have staff privileges in a minimum of one general acute care hospital under subcontract with the contractor, within the service area of the contractor.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-502 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-502 renumbered without change as Section R9-22-501, former Section R9-22-503 renumbered and amended as Section R9-22-502 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-502 repealed, new Section R9-22-502 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

### R9-22-503. Repealed

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-503 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-503 renumbered and amended as Section R9-22-502, new Section R9-22-503 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective May 30, 1986 (Supp. 86-3). Amended subsection (D) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (F) and (G) effective December 22, 1987 (Supp. 87-4). Amended subsection (I) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3).

**R9-22-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions**

**A.** A contractor or the contractor's marketing representative shall not offer or give any form of compensation or reward, or engage in any behavior or activity that may be reasonably construed as coercive, to induce or procure AHCCCS enrollment. Any marketing solicitation offering a benefit, good, or service, in excess of the covered services in Article 2 shall be deemed an inducement.

**B.** A marketing representative shall not misrepresent itself, the contracting health plan represented, or the AHCCCS program, through false advertising, false statements, or in any other manner to induce an eligible person or member of another contracting entity to enroll in the represented health plan.

1. The Administration shall deem violations of this subsection to include, but not be limited to, false or misleading claims, inferences, or representations that:
   a. An eligible person or member will lose benefits under the AHCCCS program or any other health or welfare benefits to which the eligible person or member is legally entitled, if the eligible person or member does not enroll in the represented contracting health plan;
   b. Marketing representatives are employees of the state or representatives of the Administration, a county, or any health plan other than the health plan with whom they are employed, or by whom they are reimbursed; and
   c. The represented health plan is recommended or endorsed as superior to its competition by any state or county agency, or any organization, unless the organization has certified its endorsement in writing to the health plan and the Administration.

**C.** A marketing representative shall not engage in any marketing or pre-enrollment practice that discriminates against an eligible person or a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.

**D.** The Administration shall hold a contractor responsible for the performance of any marketing representative, subcontractor or agent, program, or process under its employ or direction and shall make the contractor subject to the contract sanctions in this Chapter.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-504 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-504 repealed, former Section R9-22-505 renumbered and adopted without change as Section R9-22-504 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-504 repealed, former Section R9-22-528 renumbered and amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

**R9-22-505. Approval of Advertisements and Marketing Materials**

**A.** A contractor shall submit its proposed advertisements, marketing materials, and paraphernalia for review and approval by the Administration before distributing the materials or implementing the activities.

**B.** A contractor shall submit all proposed marketing materials in writing to the Administration.

**C.** The Administration shall review and approve or disapprove all marketing materials. The Administration shall include a statement of objections and recommendations in a notice of disapproval.

**D.** To minimize the expense of revising advertising or other copy, a contractor may submit the marketing materials in draft form, subject to final approval and filing of a proof or final copy.

**E.** A contractor shall provide two copies of the proof or final approved copy of marketing materials to the Administration.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-505 adopted as an emergency expired, former Section R9-22-506 adopted as an emergency now adopted, amended and renumbered as Section R9-22-505 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-505 renumbered without change as Section R9-22-504, new Section R9-22-505 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-505 renumbered and amended as Section R9-22-509, former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5). Editorial correction, spelling of "paraphernalia" in subsection (A) (Supp. 87-4). Amended effective December 8, 1997 (Supp. 97-4).

**R9-22-506. Repealed**

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-506 adopted as an emergency adopted, amended and renumbered as Section R9-22-505, former Section R9-22-507 adopted as an emergency now adopted, amended and renumbered as Section R9-22-506 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (D) effective December 22, 1987 (Supp. 87-4). Repealed effective April 13, 1990 (Supp. 90-2). New Section adopted effective December 13, 1993 (Supp. 93-4). Repealed effective December 8, 1997 (Supp. 97-4).

**R9-22-507. Member Record**

A contractor shall maintain a member service record that contains at least the following for each member:

1. Encounter data,
2. Grievances and appeals,
3. Any informal complaints, and
4. Service information.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-507 adopted as an emergency adopted, amended and renumbered as Section R9-22-506, former Section R9-22-508 adopted as an emergency now adopted, amended and renumbered as Section R9-22-507 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-507 repealed, new Section R9-22-507 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

**R9-22-508. Limitation of Benefit Coverage for Illness or Injury due to Catastrophe**

The Director may limit the scope of health care benefits provided by a prepaid capitated contractor to exclude the care of illness or injury that results from, or is greatly aggravated by, a catastrophic occurrence, including an act of declared or undeclared war, that occurs after enrollment.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-508 adopted as an emergency adopted, amended and renumbered as Section R9-22-507, former Section R9-22-509 adopted as an emergency now adopted, amended and renumbered as Section R9-22-508 as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective December 8, 1997 (Supp. 97-4).

**R9-22-509. Transition and Coordination of Member Care**

**A.** The Administration shall coordinate and implement disenrollment and re-enrollment procedures when a member's change of residency requires a change in contractor.

**B.** A contractor shall assist in the transition of members to and from other AHCCCS contractors.

1. Both the receiving and relinquishing contractor shall:
   a. Coordinate with the other contractor to facilitate and schedule appointments for medically necessary services for the transitioned member within the Administration's timelines specified in the contract. A contractor's policies and procedures regarding transition of members are subject to review and approval by the Administration;
   b. Assist in the referral of transitioned members to other community health agencies or county medical assistance programs for medically necessary services not covered by the Administration, as appropriate; and
   c. Develop policies and procedures to be followed when transitioning members who have significant medical conditions; are receiving ongoing services; or have, at the time of the transition, received prior authorization or approval for undelivered, specific services.
2. The relinquishing contractor shall notify the receiving contractor of relevant information about the member's medical condition and current treatment regimens within the timelines defined in contract;
3. The relinquishing contractor shall forward medical records and other materials to the receiving contractor. The cost of reproducing and forwarding medical records and other materials shall be borne by the relinquishing contractor;
4. Within the contract-specified timelines, the receiving contractor shall ensure that the member selects or is assigned to a primary care provider, and provide the member with:
   a. Information regarding the contractor's providers,
   b. Emergency numbers, and
   c. Instructions about how to obtain new services.

**C.** A contractor shall not use a county or nonprovider health resource alternative that diminishes the contractor's contractual responsibility or accountability for providing the full scope of covered services. Referrals made to other health agencies by a contractor, primarily to reduce expenditures incurred by the contractor on behalf of its members, may result in the application of sanctions described in this Chapter.

**D.** A contractor may transfer a member from a noncontracting provider to a contracting provider's facility as soon as a transfer will not be harmful to the member's health as authorized by the member's primary care provider or the contractor's Medical Director. A member's plan shall pay the cost of transfer.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-509 adopted as an emergency adopted, amended and renumbered as Section R9-22-508, former Section R9-22-510 adopted as an emergency now adopted and renumbered as Section R9-22-509 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-509 repealed, former Section R9-22-505 renumbered and amended as Section R9-22-509 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

**R9-22-510. Transfer of Members**

A contractor shall implement procedures to allow a member to transfer from the primary care provider of record to another primary care provider within the same contracting organization. Criteria for a transfer include, but are not be limited to:

1. Change in the member's health, requiring a different medical focus;
2. Change in the member's residency resulting in difficulty in obtaining services from the assigned primary care provider; or
3. Identification of any problem between the member and the primary care provider, resulting in deterioration of the primary care provider - member relationship.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-510 adopted as an emergency adopted and renumbered as Section R9-22-509, former Section R9-22-511 adopted as an emergency now adopted, amended and renumbered as Section R9-22-510 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-510 repealed, new Section R9-22-510 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

**R9-22-511. Fraud or Abuse**

A contractor, provider, or nonprovider shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-511 adopted as an emergency adopted, amended and renumbered as Section R9-22-510, former Section R9-22-512 adopted as an emergency now adopted, amended and renumbered as Section R9-22-511 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-511 repealed, new Section R9-22-511 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

**R9-22-512. Release of Safeguarded Information by the Administration and Contractors**

**A.** The Administration, contractors, providers, and noncontracting providers shall safeguard information concerning an applicant, eligible person, or member, which includes the following:

1. Name and address;

2. Social Security number;
3. Social and economic conditions or circumstances;
4. Agency evaluation of personal information;
5. Medical data and services, including diagnosis and history of disease or disability;
6. State Data Exchange (SDX) tapes from the U.S. Social Security Administration; and
7. Information system tapes from the Arizona Department of Economic Security.

**B.** The restriction upon disclosure of information does not apply to:
1. Summary data;
2. Statistics;
3. Utilization data; and
4. Other information that does not identify an applicant, eligible person, or member.

**C.** The Administration, contractors, providers, and noncontracting providers shall use or disclose information concerning an eligible person, applicant, or member only under the conditions specified in subsection (D), (E), and (F) and only to:
1. The person concerned,
2. Individuals authorized by the person concerned, and
3. Persons or agencies for official purposes.

**D.** Safeguarded information shall be viewed by or released to only:
1. An applicant;
2. An eligible person;
3. A member; or
4. An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:
   a. An Administration employee or its authorized representative, county eligibility official, or responsible caseworker is present during the examination of the eligibility record; or
   b. As outlined in subsection (E) after written notification to the provider, and at a reasonable time and place.

**E.** An eligibility case record, medical record, and any other AHCCCS-related confidential and safeguarded information regarding an eligible person, member, applicant, or unemancipated minor shall be released to individuals authorized by the eligible person, member, applicant, or unemancipated minor only under the following conditions:
1. Authorization for release of information is obtained from the eligible person, member, applicant, or designated representative;
2. Authorization used for release is a written document, separate from any other document, that specifies the following information:
   a. Information or records, in whole or in part, which are authorized for release;
   b. To whom release is authorized;
   c. The period of time for which the authorization is valid, if limited; and
   d. A dated signature of the adult and mentally competent member, eligible person, applicant, or designated representative. If the eligible person, member, or applicant is a minor, the signature of a parent, custodial relative, or designated representative shall be required unless the minor is sufficiently mature to understand the consequences of granting or denying authorization. If the eligible person, member, or applicant is mentally incompetent, authorization shall be according to A.R.S. § 36-509;
3. If an appeal or grievance is filed, the eligible person, member, applicant, or designated representative shall be permitted to review and obtain or copy any nonprivileged record necessary for the proper presentation of the case.

**F.** Release of safeguarded information to individuals or agencies for official purposes:
1. Official purposes directly related to the administration of the AHCCCS program are:
   a. Establishing eligibility and post-eligibility treatment of income, as applicable;
   b. Determining the amount of medical assistance;
   c. Providing services for eligible persons and members;
   d. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the AHCCCS program;
   e. Performing evaluations and analyses of AHCCCS operations;
   f. Filing liens on property as applicable;
   g. Filing claims on estates, as applicable; and
   h. Filing, negotiating, and settling medical liens and claims.
2. For official purposes related to the administration of the AHCCCS program and only to the extent required in performance of duties, safeguarded information, including case records and medical records, may be disclosed to the following persons without the consent of the applicant, member, or eligible person:
   a. Employees of the Administration;
   b. Employees of the U.S. Social Security Administration;
   c. Employees of the Arizona Department of Economic Security;
   d. Employees of the Arizona Department of Health Services;
   e. Employees of the U.S. Department of Health and Human Services;
   f. Employees of contractors, program contractors, providers, and subcontractors;
   g. Employees of the Arizona Attorney General's Office; or
   h. Employees of counties including Boards of Supervisors, AHCCCS eligibility offices, and the County Attorney, as applicable.
3. Law enforcement officials:
   a. Information may be released to law enforcement officials without the applicant's, eligible person's, or member's written or verbal consent, for the purpose of an investigation, prosecution, or criminal or civil proceeding relating to the administration of the AHCCCS program.
   b. Medical record. The Administration and contractors shall release safeguarded information contained in a member's medical record to law enforcement officials without the member's consent only if the member is suspected of fraud or abuse against the AHCCCS program.
   c. A contractor shall release the medical record or information in the case record or other information developed in case management or utilization management operations without the member's written or verbal consent, for the purpose of an investigation, prosecution, or similar criminal proceeding not in connection with the Administration, only if the law enforcement official requesting the information has statutory authority to obtain the information.
4. The Administration may release safeguarded information including case records and medical records to a review

committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant, eligible person, or member.

5. In accordance with the 1634 Agreement between the State of Arizona and the U.S. Department of Health and Human Services, a recipient of information or records disclosed or used for an official purpose shall comply with the 1634 Agreement, dated October 1, 1982, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
6. Providers shall furnish requested records to the Administration and its contractors at no charge.

**G.** The holder of a medical record of a former applicant, eligible person, or member shall obtain written consent from the former applicant, eligible person, or member before transmitting the medical record to a primary care provider.

**H.** Subcontractors are not required to obtain written consent from an eligible person or member before transmitting the eligible person's or member's medical records to a physician who:

1. Provides a service to the eligible person or member under subcontract with the program contractor,
2. Is retained by the subcontractor to provide services that are infrequently used or are of an unusual nature, and
3. Provides a service under the contract.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-512 adopted as an emergency adopted, amended and renumbered as Section R9-22-511, former Section R9-22-513 adopted as an emergency now adopted and renumbered as Section R9-22-512 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-512 repealed, new Section R9-22-512 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4).

**R9-22-513. Discrimination Prohibition**

**A.** A contractor, provider, and nonprovider shall not discriminate against an eligible person or member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental disability in accordance with Title VI of the U.S. Civil Rights Act of 1964, 42 U.S.C., Section 2000d, and rules and regulations promulgated according to, or as otherwise provided by law. For the purpose of providing covered service under contract according to A.R.S. Title 36, Ch. 29, discrimination includes, but is not limited to, the following if done on the grounds of the eligible person's or member's race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental disability:

1. Denying or providing an eligible person or member any covered service or availability of a facility;
2. Providing to an eligible person or member any covered service that is different, or is provided in a different manner or at a different time from that provided to other AHCCCS members under contract, other public or private members, or the public at large except when medically necessary;
3. Subjecting an eligible person or member to segregation or separate treatment in any manner related to the receipt of any covered service; restricting a member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and
4. Assigning to an eligible person or member times or places for the provision of services that are different from those assigned to other AHCCCS members under contract.

**B.** All provisions in this Section shall not apply to an eligible person defined as eligible according to A.R.S. § 36-2901 (4)(d) through (4)(g), who is not required by statute or these rules to obtain health care services at a county-owned and operated facility, if the health care facility is awarded a contract as an AHCCCS provider. A person eligible according to A.R.S. § 36-2901 (4)(b) shall have freedom of choice in selecting membership with an AHCCCS contractor in all instances in which more than one choice of contractor is available. However, an eligible person shall become a member of a county program and receive services in a county facility, if a county is the only AHCCCS contractor for the eligible person in the service area.

**C.** A contractor shall take affirmative action to ensure that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental disability, except where medically indicated.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-513 adopted as an emergency adopted and renumbered as Section R9-22-512, former Section R9-22-514 adopted as an emergency now adopted, amended and renumbered as Section R9-22-513 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-513 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-513 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

**R9-22-514. Equal Opportunity**

A contractor shall, in all solicitations or advertisements for employees placed by, or, on behalf of the contractor:

1. Specify that it is an equal opportunity employer;
2. Send a notice provided by the Administration to each labor union representative or worker with a collective bargaining agreement, or other contract or understanding, stating that the contractor is an equal opportunity employer; and
3. Post copies of the notice in conspicuous places available to employees and applicants for employment.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-514 adopted as an emergency adopted, amended and renumbered as Section R9-22-513, former Section R9-22-515 adopted as an emergency now adopted, amended and renumbered as Section R9-22-514 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-514 repealed, former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

**R9-22-515. Repealed**

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-515 adopted as an emergency adopted, amended and renumbered as Section R9-22-514, former Section R9-22-517 adopted as an emergency now adopted, amended and renumbered as Section R9-22-515

as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-515 repealed, former Section R9-22-522 renumbered and amended as Section R9-22-515 effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

**R9-22-516. Renumbered**

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-516 adopted as an emergency expired, former Section R9-22-518 adopted as an emergency now adopted, amended and renumbered as Section R9-22-516 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-516 renumbered as Section R9-22-513 effective October 1, 1985 (Supp. 85-5).

**R9-22-517. Renumbered**

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-517 adopted as an emergency adopted, amended and renumbered as Section R9-22-515, former Section R9-22-519 adopted as an emergency now adopted and renumbered and amended as Section R9-22-517 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5).

**R9-22-518. Information to Enrolled Members**

**A.** Each contractor shall produce and distribute printed information materials to each member or family unit within 10 days of receipt of notification of enrollment from the Administration. The information materials shall be written in English and all languages used by 200 members or 5%, whichever is greater, of the enrolled population. The informational materials must meet the requirements specified in the contractor's current contract.

**B.** A contractor shall provide a member with the name, address, and telephone number of the member's primary care provider within 10 days from the date of enrollment. This notice shall include information on how the member may change primary care providers, if dissatisfied with the primary care provider assigned.

**C.** A contractor shall revise and distribute to members a service guide insert describing any change that the contractor proposes to make in services provided or service locations. The insert shall be distributed to all affected members or family units at least 14 days before a planned change. Notification shall be provided as soon as possible when unforeseen circumstances require an immediate change in services, sites or locations.

**D.** A contractor shall submit informational and educational materials for approval by the Administration before distributing the materials to members and families.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-518 adopted as an emergency adopted, amended and renumbered as Section R9-22-516, former Section R9-22-520 adopted as an emergency now adopted, amended and renumbered as Section R9-22-518 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-518 repealed, new Section R9-22-518 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

**R9-22-519. Repealed**

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-519 adopted as an emergency adopted, amended and renumbered as Section R9-22-517, former Section R9-22-521 adopted as an emergency now adopted, amended and renumbered as Section R9-22-519 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-519 repealed, new Section R9-22-519 adopted effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

**R9-22-520. Expired**

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-520 adopted as an emergency adopted, amended and renumbered as Section R9-22-518, former Section R9-22-522 adopted as an emergency now adopted, amended and renumbered as Section R9-22-520 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-520 repealed, new Section R9-22-520 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 4851, effective October 9, 2002 (Supp. 02-4).

**R9-22-521. Program Compliance Audits**

**A.** The Administration shall conduct a program compliance audit of a contractor at least once every 12 months during the term of its contract with the contractor. Unless the Administration determines that advance notice will render a program compliance audit less useful, a contractor will be notified approximately three weeks in advance of the date of an onsite program compliance audit. The Administration may conduct, without prior notice, inspections of contractor facilities or perform other elements of a program compliance audit, either in conjunction with the program compliance audit or as part of an unannounced inspection program.

**B.** A review team may perform any or all of the following procedures:

1. Conduct private interviews and group conferences with members, physicians, and other health professionals and members of the contractor's administrative staff including, but not limited to, the contractor's principal management persons;
2. Examine records, books, reports, and papers of the contractor and any management company, and all providers or subcontractors providing health care and other services to the health plan. The examination may include, but not be limited to: minutes of medical staff meetings, peer review and quality of care review records, duty rosters of medical personnel, appointment records, written procedures for the internal operation of the health plan, contracts and correspondence with members and with providers of health care services and other services to the plan, and additional documentation deemed necessary by the Administration to review the quality of medical care.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-521 adopted as an emergency adopted, amended and renumbered as Section R9-22-519, former Section R9-22-523 adopted as an emergency now

adopted, amended and renumbered as Section R9-22-521 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-521 repealed, new Section R9-22-521 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

***Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. This Section was subsequently amended through the regular rulemaking process.***

**R9-22-522. Quality Management/Utilization Management (QM/UM) Requirements**

**A.** A contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements specified in this Section and in contract. The contractor shall ensure compliance with QM/UM requirements that are accomplished through delegation or subcontract with another party.

**B.** A contractor shall:
1. Submit a written QM/UM plan that includes a description of the systems, methodologies, protocols, and procedures to be used in:
   a. Monitoring and evaluating the types of services,
   b. Identifying the numbers and costs of services provided,
   c. Assessing and improving the quality and appropriateness of care and services,
   d. Evaluating the outcome of care provided to members, and
   e. Determining the steps and actions necessary to improve service delivery.
2. Submit the QM/UM plan on an annual basis within timelines specified in contract. If the QM/UM plan is changed during the year, the contractor shall submit the revised plan before implementation;
3. Receive approval from the Administration before implementing the initial QM/UM plan;
4. Ensure that a QM/UM committee operates under the control of the contractor's medical director, and includes representation from medical and executive management personnel. The committee shall:
   a. Oversee the development, revision and implementation of the QM/UM plan; and
   b. Ensure and allocate qualified QM/UM personnel and sufficient resources to implement the contractor's QM/UM activities.
5. Ensure that the QM/UM activities include at least:
   a. Prior authorization for non-emergency or scheduled hospital admissions;
   b. Concurrent review of inpatient hospitalization;
   c. Retrospective review of hospital claims;
   d. Program and provider audits designed to detect over or under utilization, service delivery effectiveness, and outcome;
   e. Medical records audits;
   f. Surveys to determine satisfaction of members;
   g. Assessment of the adequacy and qualifications of the contractor's provider network;
   h. Review and analysis of QM/UM data; and
   i. Other activities necessary to improve the quality of care and the efficient, cost effective delivery and utilization of services.

**C.** An eligible person's or member's primary care provider shall maintain medical records that:
1. Are detailed and comprehensive and identify:
   a. All medically necessary services provided to the member by the contractor and the subcontractors, and
   b. All emergency services provided by nonproviders for an eligible person or member.
2. Conform to professional medical standards and practices for documentation of medical diagnostic and treatment data;
3. Facilitate follow-up treatment; and
4. Permit professional medical review and medical audit processes.

**D.** A subcontractor or its designee shall forward medical records or copies of medical records of all members assigned to the subcontractor or for whom the subcontractor has provided services, within 30 days following termination of a contract between the subcontractor and the contractor.

**E.** The Administration shall monitor contractors and their providers to ensure compliance with Administration QM/UM requirements and adherence to the contractor QM/UM plan.
1. A contractor and its providers shall cooperate with the Administration in the performance of its QM/UM monitoring activities; and
2. A contractor and its providers shall develop and implement mechanisms for correcting deficiencies identified through the Administration's QM/UM monitoring.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-522 adopted as an emergency adopted, amended and renumbered as Section R9-22-520, former Section R9-22-524 adopted as an emergency now adopted and renumbered as Section R9-22-522 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-522 renumbered and amended as Section R9-22-515, new Section R9-22-522 adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4).

**R9-22-523. Expired**

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-523 adopted as an emergency adopted, amended and renumbered as Section R9-22-521, former Section R9-22-525 adopted as an emergency now adopted, amended and renumbered as Section R9-22-523 as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 4851, effective October 9, 2002 (Supp. 02-4).

**R9-22-524. Continuity of Care**

A contractor shall establish and maintain a system to ensure continuity of care which shall, at a minimum, include:
1. Referring members who need specialty health care services;
2. Monitoring members with chronic medical conditions;
3. Providing hospital discharge planning and coordination including post-discharge care; and

4. Monitoring operation of the system through professional review activities.

**Historical Note**
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-524 adopted as an emergency adopted and renumbered as Section R9-22-522, former Section R9-22-526 adopted as an emergency now adopted, amended and renumbered as Section R9-22-524 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-524 repealed, new Section R9-22-524 adopted effective October 1, 1985 (Supp. 85-4). Amended effective December 8, 1997 (Supp. 97-4).

**R9-22-525. Repealed**

**Historical Note**
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-525 adopted as an emergency adopted, amended and renumbered as Section R9-22-523, former Section R9-22-527 adopted as an emergency now adopted, amended and renumbered as Section R9-22-525 as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1985 (Supp. 85-5).

**R9-22-526. Renumbered**

**Historical Note**
Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of the permanent rule identical to the emergency (Supp. 83-3). Former Section R9-22-526 repealed, new Section R9-22-526 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-1).

**R9-22-527. Renumbered**

**Historical Note**
Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5).

**R9-22-528. Renumbered**

**Historical Note**
Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-528 renumbered and amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5).

**R9-22-529. Renumbered**

**Historical Note**
Adopted as Section R9-22-529 effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5).

## ARTICLE 6. RFP AND CONTRACT PROCESS

**R9-22-601. General Provisions**

**A.** The Director has full operational authority to adopt rules for the RFP process and the award of contracts under A.R.S. § 36-2906.

**B.** This Article applies to the expenditure of all public monies by the Administration for covered services under Articles 2 and 12 of this Chapter except as otherwise provided by law. The Administration shall establish conflict-of-interest safeguards for officers and employees of this state with responsibilities relating to contracts that comply with 42 U.S.C. 1396u-2(d)(3).

**C.** The Administration shall award contracts under A.R.S. §§ 36-2904 and 36-2906 to provide services under A.R.S. § 36-2907.

**D.** The Administration is exempt from the procurement code under A.R.S. § 41-2501.

**E.** The Administration and contractors shall retain all contract records for five years under A.R.S. § 36-2903 and dispose of the records under A.R.S. § 41-2550.

**Historical Note**
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-601 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-602. RFP**

**A.** RFP content. The Administration shall include the following items in any RFP under this Article:
1. Instructions and information to an offeror concerning the proposal submission including:
   a. The deadline for submitting a proposal,
   b. The address of the office at which a proposal is to be received,
   c. The period during which the RFP remains open, and
   d. Any special instructions and information;
2. The scope of covered services under Article 2 of this Chapter and A.R.S. §§ 36-2906 and 36-2907, covered populations, geographic coverage, service and performance requirements, and a delivery or performance schedule;
3. The contract terms and conditions, including bonding or other security requirements, if applicable;
4. The factors used to evaluate a proposal;
5. The location and method of obtaining documents that are incorporated by reference in the RFP;
6. A requirement that the offeror acknowledge receipt of all RFP amendments issued by the Administration;
7. The type of contract to be used and a copy of a proposed contract form or provisions;
8. The length of the contract service;
9. A requirement for cost or pricing data;
10. The minimum RFP requirements; and
11. A provision requiring an offeror to certify that a submitted proposal does not involve collusion or other anti-competitive practices.

**B.** Proposal process.
1. After the deadline for submitting proposals, the Administration may open a proposal publicly and announce and record the name of the offeror. The Administration shall keep all other information contained in a proposal confidential. The Administration shall open a proposal for public inspection after contract award unless the Administration determines that disclosure is not in the best interest of the state.
2. The Administration shall evaluate a proposal based on the GSA and the evaluation factors listed in the RFP.
3. The Administration may initiate discussions with a responsive and responsible offeror to clarify and assure full understanding of an offeror's proposal. The Adminis-

tration shall provide an offeror fair treatment with respect to discussion and revision of a proposal. The Administration shall not disclose information derived from a proposal submitted by a competing offeror.

4. The Administration shall allow for the adjustment of covered services by expansion, deletion, segregation, or combination in order to secure the most financially advantageous proposals for the state.
5. The Administration may conduct an investigation of a person or organization who has ownership or management interests in corporate offerors or affiliated corporate organizations of an offeror.
6. The Administration may issue a written request for best and final offers. The Administration shall state in the request the date, time, and place for the submission of best and final offers.
7. The Administration shall not request best and final offers more than once unless the Administration determines that it is advantageous to the state to request additional best and final offers. The Administration shall state in the written request for best and final offers that if the offeror does not submit a notice of withdrawal or a best and final offer, the Administration shall take the most recent offer as the offeror's best and final offer.

**C.** Proposal rejection.

1. The Administration may reject an offeror's proposal if the offeror fails to supply the information requested by the Administration.
2. The offeror shall not disclose information pertaining to its proposal to any other offeror prior to contract award. The offeror may disclose proposal information to a person other than another offeror if the recipient agrees to keep the information confidential until contract award. Disclosure in violation of this subsection may be grounds for rejecting a proposal.
3. The Administration shall provide written notification to an offeror whose proposal is rejected. The rejection notice shall be part of the contract file and a public record.
4. If the Administration determines that it is in the best interest of the state, the Administration may reject any and all proposals, in whole or in part, under the RFP. The reasons for rejection shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if a proposal is rejected in whole or in part.

**D.** Proposal cancellation. If the Administration determines that it is in the best interest of the state, the Administration may cancel a RFP. The reasons for cancellation shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if a RFP is cancelled.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-602 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-603. Contract Award**

The Administration shall award a contract to the responsible and responsive offeror whose proposal is determined most advantageous to the state under A.R.S. § 36-2906. If the Administration determines that multiple contracts are in the best interest of the state, the Administration may award multiple contracts. The contract file shall contain the basis on which the award is made.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-603 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-604. Contract or Proposal Protests; Appeals**

**A.** Disputes related to contract performance. This Section does not apply to a dispute related to contract performance. A contract performance dispute is governed by Article 8 of this Chapter.

**B.** Resolution of a proposal protest. The procurement officer issuing a RFP shall have the authority to resolve proposal protests. An appeal from the decision of the procurement officer shall be made to the Director.

**C.** Filing of a protest.

1. A person may file a protest with the procurement officer regarding:
   a. A RFP issued by the Administration,
   b. A proposed award, or
   c. An award of a contract.
2. A protester shall submit a written protest and include the following information:
   a. The name, address, and telephone number of the protester;
   b. The signature of the protester or protester's representative;
   c. Identification of a RFP or contract number;
   d. A detailed statement of the legal and factual grounds of the protest including copies of any relevant documents; and
   e. The relief requested.

**D.** Time for filing a protest.

1. A protester filing a protest alleging improprieties in a RFP shall file the protest before the due date for receipt of proposals.
2. A protester filing a protest alleging improprieties that do not exist in the original RFP but are subsequently incorporated into the RFP before the due date for receipt of proposals shall file the protest prior to the amended due date for receipt of proposals.
3. In cases other than those covered in subsections (D)(1) and (2), a protester shall file a protest within 10 days after the protester knows or should have known the basis of the protest.

**E.** Stay of procurement during the protest. If a protester files a protest before the contract award, the procurement officer may issue a written stay of the contract award. In considering whether to issue a written stay of contract, the procurement officer shall consider but is not limited to considering whether:

1. A reasonable probability exists that the protest will be sustained, and

2. The stay of the contract award is in the best interest of the state.

**F.** Stay of contract award during an appeal to the Director. The Director shall automatically continue the stay of a contract award if:
1. An appeal is filed before a contract award, and
2. The procurement officer issues a stay of the contract award under subsection (E), unless
3. The Director issues a written determination that the contract award is necessary to protect the best interest of the state.

**G.** Decision by the procurement officer.
1. The procurement officer shall issue a written decision within 14 days after a protest has been filed. The decision shall contain an explanation of the basis of the decision.
2. The procurement officer shall furnish a copy of the decision to the protester by:
   a. Certified mail, return receipt requested; or
   b. Any other method that provides evidence of receipt.
3. The Administration may extend, for good cause, the time-limit for decisions in subsection (F)(1) for a time not to exceed 30 days. The procurement officer shall notify the protester in writing that the time for the issuance of a decision has been extended and the date by which a decision shall be issued.
4. If the procurement officer fails to issue a decision within the time-limits in subsection (F)(1) or (3), the protester may proceed as if the procurement officer issued an adverse decision.

**H.** Remedies.
1. If the procurement officer sustains the protest in whole or in part and determines that the RFP, proposed contract award, or contract award does not comply with applicable statutes and rules, the procurement officer shall order an appropriate remedy.
2. In determining an appropriate remedy, the procurement officer shall consider all the circumstances of the procurement or proposed procurement, including:
   a. Seriousness of the procurement deficiency,
   b. Degree of prejudice to other interested parties or to the integrity of the RFP process,
   c. Good faith of the parties,
   d. Extent of performance,
   e. Costs to the state, and
   f. Urgency of the procurement.
3. An appropriate remedy may include one or more of the following:
   a. Terminating the contract;
   b. Reissuing the RFP;
   c. Issuing a new RFP;
   d. Awarding a contract consistent with statutes, rules, and the terms of the RFP; or
   e. Any relief determined necessary to ensure compliance with applicable statutes and rules.

**I.** Appeals to the Director.
1. A person may file an appeal about a procurement officer's decision with both the Director and the procurement officer within five days from the date the decision is received. The date the decision is received shall be determined under subsection (F)(2).
2. The appeal shall contain:
   a. The information required in subsection (C)(2),
   b. A copy of the procurement officer's decision,
   c. The alleged factual or legal error in the decision of the procurement officer on which the appeal to the Director is based, and
   d. A request for hearing unless the person requests that the Director's decision be based solely upon the contract record.

**J.** Dismissal. The Director shall not schedule a hearing and shall dismiss an appeal with a written determination if:
1. The appeal does not state a basis for protest,
2. The appeal is untimely under subsection (H)(1), or
3. The appeal is moot.

**K.** Hearing. Hearings under this Section shall be conducted under R9-22-802 of this Chapter.

**Historical Note**
Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-605. Waiver of Contractor's Subcontract with Hospitals**

If a contractor is unable to obtain a subcontract with a hospital, the contractor may request in writing a waiver from the Administration as allowed by A.R.S. § 36-2906. The contractor shall state in the request the reasons a waiver is believed to be necessary and all efforts the contractor has made to secure a subcontract. The Administration shall consider the following criteria in deciding whether to grant the waiver:
1. The number of hospitals in the GSA,
2. The extent to which the contractor's physicians have staff privileges at noncontracting hospitals in the service area,
3. The size and population of, and the demographic distribution within, the service area,
4. Patterns of medical practice and care within the service area,
5. Whether the contractor has diligently attempted to negotiate a hospital subcontract with local hospitals capable of serving members in the service area,
6. Whether the contractor has any subcontracts in adjoining service areas with hospitals that are reasonably accessible to the contractor's members in the service area, and
7. Whether the contractor's members can reasonably be expected to receive all covered services in the absence of a hospital subcontract.

**Historical Note**
Adopted effective January 31, 1986 (Supp. 86-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-606. Contract Compliance Sanction**

**A.** The Director may impose one or more of the following sanctions upon a contractor that violates any provision of this Chapter or of a contract:
1. Suspend any or all further member enrollment, by choice or assignment, for a period of time commensurate with the nature, term, and severity of the violation.
2. Withhold a percentage of the contractor's capitation prepayment, commensurate with the nature, term, and severity of the violation.

**B.** The Director shall consider the nature, severity, and length of the violation when determining a sanction.

**C.** The Director shall provide a contractor with written notice specifying grounds for the sanction which are commensurate with the nature, term, and severity of the violation and one or more of the following:

1. Length of suspension,
2. Amount to be forfeited, or
3. Prepayment to be withheld.

**D.** Nothing contained in this Section shall be construed to prevent the Administration from imposing sanctions as provided in contract under A.R.S. § 36-2903.

**Historical Note**
New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

## ARTICLE 7. STANDARDS FOR PAYMENTS

**R9-22-701. Scope of the Administration's Liability**
The Administration shall bear no liability for providing covered services to or completing a plan of treatment for any member beyond the date of eligibility termination.

**Historical Note**
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-701 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-701 repealed, new Section R9-22-701 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-702. Prohibitions Against Charges to Members**

**A.** Except as provided in subsection (B), an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration that the person was ineligible for AHCCCS on the date of service:
1. Charge, submit a claim to, demand or collect payment from a person claiming to be AHCCCS eligible; or
2. Refer or report a person claiming to be AHCCCS eligible to a collection agency or credit reporting agency.

**B.** An AHCCCS registered provider may charge, submit a claim to, demand or collect payment from a member as follows:
1. To collect an authorized copayment;
2. To pay for non-covered services;
3. To recover from a member that portion of a payment made by a third-party to the member if the payment duplicates AHCCCS paid benefits and is not assigned to a contractor under R9-22-1002(B). An AHCCCS registered provider that makes a claim shall not charge more than the actual, reasonable cost of providing the covered service; or
4. To bill a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused the payment to the provider to be reduced or denied.

**Historical Note**
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-702 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text identical to the emergency (Supp. 83-3). Former Section R9-22-702 repealed, new Section R9-22-702 adopted effective October 1, 1983 (Supp. 83-5). Amended by adding subsection (B) effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3).

**R9-22-703. Claims Submission to the Administration**

**A.** AHCCCS registered providers. An AHCCCS registered provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904(E) and 42 CFR 431.107(b) as of April 6, 1992, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

**B.** Timely Submission of Claims.
1. Under A.R.S. § 36-2904(H)(3), the Administration regards a paper or electronic claim as submitted on the date that it is received by the Administration. The Administration shall do one or more of the following for each claim it receives:
   a. Place a date stamp on the face of the claim;
   b. Assign a system-generated claim reference number; or
   c. Assign a system-generated date-specific number.
2. Except as provided in subsection (B)(6), an AHCCCS registered provider shall initially submit a claim for covered services to the Administration not later than:
   a. Six months from the date of service, or
   b. Six months from the date of eligibility posting, whichever is later.
3. The Administration shall deny a claim if the claim is not initially submitted within:
   a. The six-month period from the date of service, or
   b. Six months from the date of eligibility posting, whichever is later.
4. Except as provided in subsection (B)(6), if an AHCCCS registered provider submits an initial claim within the six-month period noted in subsection (B)(2), the AHCCCS registered provider shall submit a clean claim to the Administration not later than:
   a. Twelve months from the date of service; or
   b. Twelve months from the date of eligibility posting, whichever is later.
5. A claim is clean when it meets the requirements under A.R.S. § 36-2904(H).
6. Under A.R.S. § 36-2904, an AHCCCS registered provider shall:
   a. Initially submit a claim for inpatient hospital services not later than six months from the date of member discharge for each claim, and
   b. Submit a clean claim for inpatient hospital services not later than 12 months from the date of discharge for each claim.
7. A contractor shall submit a reinsurance claim for payment as specified in contract.

**C.** Claims Processing
1. The Administration shall notify the AHCCCS registered provider with a remittance advice when a claim is processed for payment.
2. The Administration shall pay valid clean claims in a timely manner according to 42 CFR 447.45, February 15, 1990, which is incorporated by reference and on file with the Administration and the Office of the Secretary of

State. This incorporation by reference contains no future editions or amendments.

a. 90 percent of valid clean claims shall be paid within 30 days of the date of receipt of the claim;
b. 99 percent of valid clean claims shall be paid within 90 days of the date of receipt of the claim; and
c. The remaining one percent of valid clean claims shall be paid within 12 months of the date of receipt of a claim.

3. A claim is paid on the date indicated on the disbursement check.
4. A claim is denied as of the date of the remittance advice.
5. The Administration shall process a hospital claim according to R9-22-712.

**D.** Overpayments for AHCCCS Services.
1. An AHCCCS registered provider shall notify the Administration when the provider discovers an overpayment was made by the Administration.
2. The Administration shall recoup an overpayment from a future claim cycle if an AHCCCS registered provider fails to return the incorrect payment amount to the Administration.

**E.** Postpayment Claims Review.
1. The Administration shall conduct postpayment review of claims paid by the Administration if monies have been erroneously paid to an AHCCCS registered provider.
2. The Administration shall recoup an overpayment from a future claim cycle if an AHCCCS registered provider fails to return the incorrect payment amount to the Administration.
3. The Administration shall document any recoupment of an overpayment on a remittance advice.
4. An AHCCCS registered provider may file a grievance or request for hearing under Article 8 of this Chapter if the AHCCCS registered provider disagrees with the recoupment action.

**F.** Claims Review.
1. An AHCCCS registered provider shall:
   a. Obtain prior authorization from the Administration for non-emergency hospital admissions and covered services as specified in Articles 2 and 12 of this Chapter,
   b. Notify the Administration of hospital admissions under Article 2, and
   c. Make records available for review by the Administration.
2. The Administration shall reduce payment of or deny claims if an AHCCCS registered provider fails to obtain prior authorization or to notify the Administration under Article 2 and this Article.
3. The Administration may conduct prepayment medical review and post-payment review on all hospital claims, including outlier claims.
4. If the Administration issues prior authorization for a specific level of care but subsequent medical review indicates that a different level of care was medically appropriate, the claim shall be paid, or adjusted to pay, for the cost of the appropriate level of care.
5. Post-payment reviews shall comply with A.R.S. § 36-2903.01.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R-22-703 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-703 repealed, new Section R9-22-703 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (1) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective September 16, 1987 (Supp. 87-3). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3).

**R9-22-704. Transfer of Payments**

**A.** Business agent. For purposes of this Section, a business agent is a firm such as a billing service or accounting firm that renders statements and receives payment in the name of the contractor or AHCCCS registered provider.

**B.** Allowable transfer of payments. The Administration or a program contractor may make payments to other than an AHCCCS registered provider, and the Administration may make payments to other than a program contractor after considering whether:
1. There is an assignment to a government agency or there is an assignment under a court order; or
2. A business agent's compensation is:
   a. Related to the cost of processing the statements; and
   b. Not dependent upon the actual collection of payment.

**C.** Payment to physicians, dentists, or other health professionals. The Administration or a program contractor shall make payments to physicians, dentists, or other health professionals as follows:
1. To the employer of the physician, dentist, or other health professional, if the physician, dentist or other health professional is required, as a condition of employment, to relinquish fees to the employer;
2. To a foundation, plan, consortium or other similar organization, including a health care service organization, that furnishes health care through an organized health care delivery system, if there is a contractual arrangement between the organization and the person furnishing the services under which the organization submits a claim for the services; or
3. To the facility in which the service is provided, if there is a contractual relationship between the facility and the physician, dentist, or other health professional furnishing the services under which the facility submits the claim for the services.

**D.** Prohibition of transfer of payments for contractors or AHCCCS registered providers. A contractor or an AHCCCS registered provider shall not assign all or part of AHCCCS payments for covered services furnished to a member to any party except as specified in this Section.

**E.** Prohibition of transfer of payments to factors. The Administration shall not make payment for covered services furnished to a member by a contractor or an AHCCCS registered provider to, or through a factor, either directly, or by virtue of a power of attorney given to the factor.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-704 adopted as an emergency now adopted and amended as a permanent rule effective August 30 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended subsection A., Paragraph 2. effective October 1, 1985 (Supp. 85-5).

Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3).

**R9-22-705. Payments by Contractors**

**A.** Authorization. A contractor shall pay for all admissions and covered services rendered to its members if a covered service or an admission has been arranged by a contractor's agent or an employee, a subcontracting provider, or other individual acting on a contractor's behalf and if necessary authorization has been obtained. A contractor shall not require prior authorization for a medically necessary covered service provided during any prior period for which a contractor is responsible. A contractor is not required to pay a claim for a covered service that is:

1. Submitted more than six months after the date of the service or more than six months after the date of eligibility posting, whichever is later, or
2. Submitted as a clean claim more than 12 months after the date of the service or more than 12 months after the date of eligibility posting, whichever is later.

**B.** Timeliness of provider claim payment.

1. A contractor shall reimburse, or provide written notice for a claim that is denied or reduced by a contractor, to a subcontracting provider for the provision of medically necessary health care services to a contractor's member, within the time period specified by the subcontract.
2. Unless the subcontract specifies otherwise, a contractor shall pay valid clean claims according to 42 U.S.C. 1396u-2, August 5, 1997, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments and states that:
   a. 90% of valid clean claims shall be paid within 30 days of the date of receipt of a claim,
   b. 99% of valid clean claims shall be paid within 90 days of the date of receipt of a claim, and
   c. The remaining 1% of valid clean claims shall be paid within 12 months of the date of receipt of the claim.
3. Unless the subcontract specifies otherwise, a contractor shall provide notice of a denial or a reduction of a claim for:
   a. 90% of the claims within 30 days of the date of receipt of a claim,
   b. 99% of the claims within 90 days of the date of receipt of a claim, and
   c. The remaining 1% of the claims within 12 months of the date of receipt of a claim.
4. A notice of denial or reduction shall include a statement describing the right to grieve the contractor's denial or reduction of a claim according to Article 8.

**C.** Date of Claim. A contractor's date of receipt of an inpatient or an outpatient hospital claim shall be the date the claim is received by the contractor as indicated by the date stamp on the claim, the claim reference number, or the date-specific number system assigned by the contractor. A hospital claim shall be considered paid on the date indicated on the disbursement check. A denied hospital claim shall be considered adjudicated on the date of its denial. A claim that is pending for additional supporting documentation shall receive a new date of receipt upon receipt of the additional documentation; however, a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01(J) or 36-2904(K), as applicable, will not receive a new date of receipt. A contractor and a hospital may, through a contract approved as specified in R9-22-715(A), adopt a method for identifying, tracking, and adjudicating a claim that is different from the method described in this subsection.

**D.** Payment for medically necessary outpatient hospital services.

1. A contractor shall reimburse a subcontracting and a noncontracting provider for the provision of outpatient hospital services rendered on or after March 1, 1993, at either a rate specified by a subcontract or, in absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges. Subcontract rates, terms, and conditions are subject to review, and approval or disapproval, under A.R.S. § 36-2904(K)(1)(b) and A.A.C. R9-22-715.
2. A contractor shall pay for all emergency care services rendered to a member by a noncontracting provider or a nonprovider when the services:
   a. Are rendered according to the prudent layperson standard specified in R9-22-210;
   b. Conform to the definitions of emergency medical of behavioral health services in Articles 1 and 12, and conform to the emergency behavioral health emergency services requirements in R9-22-1205(E); and
   c. Conform to the notification requirements in Article 2.

**E.** Payment for inpatient hospital services. A contractor shall reimburse an out-of-state hospital for the provision of hospital services at negotiated discounted rates, the Arizona average cost-to-charge ratio multiplied by covered charges or, if reasonably and promptly available, the Medicaid rate in effect at the time a service is provided in the state in which the hospital is located, whichever is lowest. A contractor shall reimburse an in-state subcontractor and a noncontracting provider for the provision of inpatient hospital services rendered with an admission date on or after March 1, 1993, at either a rate specified by subcontract or, in absence of the subcontract, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and A.A.C. R9-22-712. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904(K)(1)(b) and A.A.C. R9-22-715. This subsection does not apply to a contractor participating in the pilot program described in R9-22-718.

**F.** Payment for inpatient emergency behavioral health services. A contractor shall reimburse a provider for inpatient emergency behavioral health services as specified in R9-22-204 and R9-22-210 for members eligible according to A.R.S. § 36-2901(4)(a), (b), (c), (h), or (j). The payment methodology shall be as specified in R9-22-705 or R9-22-718.

**G.** Payment for observation days. A contractor may reimburse a subcontracting and a noncontracting provider for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges.

**H.** Review of hospital claims.

1. If a contractor and a hospital do not agree on reimbursement levels, terms, and conditions, the reimbursement levels established under A.R.S. § 36-2903.01 and A.A.C. R9-22-712 or R9-22-718 shall apply. In these cases, a hospital shall obtain prior authorization from an appropriate contractor for nonemergency admissions. A contractor shall consider the medical condition of a member, length of stay, and other factors when issuing its prior authorization. A contractor shall not require prior authorization for medically necessary services provided during any prior period for which the contractor is responsible. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of the contract regarding utilization control activities. Failure to obtain prior

authorization when it is required shall be cause for nonpayment or denial of a claim. A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and make a hospital's medical records, specific to a member enrolled with a contractor, available for review.

2. Regardless of prior authorization or concurrent review activities, all hospital claims, including outlier claims, are subject to prepayment medical review and post-payment review by a contractor. Post-payment reviews shall be consistent with A.R.S. § 36-2903.01(O), and an erroneously paid claim is subject to redeployment. If prior authorization was given for a specific level of care, but medical review of a claim indicates that a different level of care was appropriate, a contractor may adjust a claim to reflect the more appropriate level of care. An adjustment in level of care shall be effective on the date when the different level of care was medically appropriate.
3. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures different from those in this subsection if a subcontract binds both parties and meets the requirements of R9-22-715.

**I.** Timeliness of hospital claim payment. Payment by a contractor for inpatient hospital admissions and outpatient hospital services on and after March 1, 1993, shall be subject to Laws 1993, 2nd Special Session, Ch. 6, § 29, as amended by Laws 1995, 1st Special Session, Ch. 5, § 8; Laws 1993, 2nd Special Session, Ch. 6, § 27, as amended by Laws 1995, 1st Special Session, Ch. 5, § 6; and A.R.S. § 36-2903.01(J)(6).

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-705 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of the amended rule identical to emergency (Supp. 83-3). Former Section R9-22-705 repealed, new Section R9-22-705 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment adopted effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (C) effective October 1, 1987; amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended subsections (A) and (C) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4).

**R9-22-706. Payments by the Administration for Services Provided to Eligible Persons**

**A.** Payment for emergency and medically necessary non-hospital outpatient services. The Administration shall make payments as defined in R9-22-710 for emergency and medically necessary non-hospital services provided to eligible persons.

1. For dates of service on or before September 30, 1997, emergency services provided to the indigent, the medically needy, and eligible low-income children from the date of notification pursuant to R9-22-313 to the date of enrollment with a prepaid capitated contractor shall be paid at the capped fee-for-service rate or billed charges, whichever is lower. On the date of notification to the AHCCCS Administration, the county shall notify the AHCCCS Administration of the amount of medical expenses necessary to satisfy the spend down requirement of R9-22-321 and incurred by the household, if any, during the period of the Administration's retroactive liability.
2. For dates of service on or before September 30, 1997, medically necessary services provided to categorically eligible persons and eligible assistance children from the effective date of eligibility to the date of enrollment with a prepaid capitated contractor shall be paid at the capped fee-for-service rate or billed charges, whichever is less.

**B.** Indian Health Service. The Administration shall pay IHS the all-inclusive inpatient, outpatient, or ambulatory surgery rates published in the *Federal Register* for AHCCCS-covered services provided in IHS facilities. Except as provided in R9-22-708, IHS medical service referrals for eligible Native Americans made to off-reservation contractors, providers, noncontracting providers, or nonproviders shall be prior authorized.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-706 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-706 repealed, new Section R9-22-706 adopted effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Amended as an emergency effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment adopted effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsections (A), (D), (E), (F), and (G) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (F) effective December 22, 1987 (Supp. 87-4). Amended subsections (A) and (F) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3).

**R9-22-707. Payments for Newborns**

If a mother is enrolled on the date of her newborn's birth, a contractor shall be financially liable under the mother's capitation to provide all AHCCCS-covered services to the newborn from the date of birth until the Administration is notified of the birth.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-

3). Former Section R9-22-707 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Repealed as a permanent action effective May 16, 1983 (Supp. 83-3). New Section R9-22-707 adopted effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Former Section R9-22-707 repealed, new Section R9-22-707 adopted effective October 1, 1985 (Supp. 85-5). Former Section R9-22-707 repealed, new Section R9-22-707 adopted effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3).

**R9-22-708. Payment for services provided to eligible Native Americans residing on reservation**

**A.** Categorically eligible Native Americans may enroll with a contractor in accordance with Article 3 of these rules.

**B.** Categorically eligible Native Americans who do not select an AHCCCS contractor and indigent and medically needy Native Americans shall be assigned in accordance with Article 3 of these rules.

**C.** Providers and nonproviders shall comply with prior authorization requirements of the Administration, as set forth in Article 2 of these rules, and of contractors.

**D.** Contractors other than the Indian Health Service providing care to eligible Native Americans shall be reimbursed on a capitation basis.

**E.** Once a Native American has enrolled with a contractor, no referral care rendered after the date of enrollment shall be reimbursable by a contractor unless the care is rendered pursuant to a referral or prior authorization made by the contractor of record.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-708 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-708 repealed, new Section R9-22-708 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-708 renumbered and amended as Section R9-22-709, new Section R9-22-708 adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5).

**R9-22-709. Contractor's Liability to Hospitals for the Provision of Emergency and Subsequent Care**

**A.** A contractor is liable for the cost of services for an emergency medical or acute mental health condition of a member only until the member's condition is stabilized and the member is transferable, or until the member is discharged following stabilization subject to the requirements of A.R.S. § 36-2909 and Article 2 of this Chapter.

**B.** Subject to subsection (A), if a member cannot be transferred following stabilization to a facility that has a subcontract with the contractor of record, the contractor of record shall pay for all appropriately documented, prior authorized, and medically necessary treatment provided to the member before the discharge date or transfer under R9-22-705.

**C.** If a member refuses transfer from a noncontracting provider or noncontracting hospital to a hospital affiliated with the member's contractor of record, neither the Administration nor the contractor shall be liable for any costs incurred after the date of refusal if:

1. After consultation with the member's contractor of record, the member continues to refuse the transfer; and
2. The member has been provided and signs a written statement, before the date the member is liable for payment, informing the member of the medical and financial consequences of refusing to transfer. If the member refuses to sign a written statement, a statement signed by two witnesses indicating that the member was informed may be substituted.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-709 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-709 repealed, new Section R9-22-709 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-709 renumbered and amended as Section R9-22-713, former Section R9-22-708 renumbered and amended as Section R9-22-709 effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

***Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.***

**R9-22-710. Capped Fee-for-service Payments for Non-hospital Services**

**A.** Service codes. The Administration shall maintain a current copy of the following code manuals at the central office of the Administration for reference use during customary business hours:

1. The Physicians' Current Procedural Terminology (CPT) and Health Care Financing Administration Common Procedure Coding System (HCPCS). These manuals identify medical services and procedures performed by physicians and other providers.
2. The AHCCCS Transportation, Supply, Equipment, and Appliance codes. These codes identify applicable services or supplied items.
3. The International Classification of Diseases.
4. Nationally recognized pharmacy coding manual.

**B.** Fee schedule. The Administration shall pay providers, including noncontracting providers, at the lesser of billed charges or the capped fee-for-service rates specified in subsections (B)(1) through (5) unless a different fee is specified by contract between the Administration and the provider, or is otherwise required by law. The Administration shall provide notice of changes in methods and standards for setting payment rates for services in accordance with 42 CFR 447.205, effective

December 19, 1983, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

1. Physician services. Fee schedules for payment for physicians services are on file at the central office of the Administration for reference use during customary business hours.
2. Pharmacy services. Fee schedules for payment for pharmacy services are exempt from rulemaking procedures under A.R.S. § 41-1005, but are subject to 42 CFR 447.331 through 447.332, effective July 31, 1987, which is incorporated by reference and on file with the Administration and the Office of Secretary of State. These incorporations by reference contain no further editions or amendments.
3. Dental services. Fee schedules for payment for dental services are on file at the central office of the Administration for reference use during customary business hours.
4. Transportation services:
   a. Ground ambulance services. Fee schedules for payment for ambulance services are on file at the central office of the Administration for reference use during customary business hours. For ambulance providers that have charges established by the Arizona Department of Health Services (ADHS), the fee schedule amount is 80% of the ambulance provider's ADHS-approved fees for covered services. For ambulance providers whose fees are not established by ADHS, the fee schedule amount is 80% of the ambulance provider's billed charges or the capped fee-for-service amount for covered services, whichever is less.
   b. Air ambulance services. Fee schedules for payment for air ambulance services are on file at the central office of the Administration for reference use during customary business hours.
   c. Nonambulance services. Fee schedules for payment for nonambulance services are on file at the central office of the Administration for reference use during customary business hours.
5. Medical equipment. Fee schedules for payment for medical equipment are on file at the central office of the Administration for reference use during customary business hours. The Administration shall reimburse providers once for durable medical equipment (DME) during any two-year period, unless the Administration determines that DME replacement within that period is medically necessary for the member. Unless authorized by the Administration, no more than one repair and adjustment shall be reimbursed during any two-year period.

**C.** Capped fee-for-service medical cost pool and payment. The Administration may establish a capped fee-for-service medical cost pool for each county in which there are capped fee-for-service physician contractors. The Administration shall pay all physician fees out of this pool. Fifteen percent of allowable physician fees shall be withheld in the pool. At the end of a contract period, the Administration shall divide any surplus or deficit remaining in the pool evenly between the Administration and the participating physicians subject to the following:

1. The physician withhold shall be used to offset the physician portion of any deficit. Physicians shall not be responsible for any deficit greater than the aggregate amount withheld. The Administration shall return all withholds not needed to fund a deficit on a pro rata basis.
2. The Administration shall divide the physician portion of any surplus so two-thirds goes to primary care physicians and one-third to referral physicians. These portions shall be divided pro rata among the physicians in each category subject to an upper limit. The physician portion of any surplus is limited so referral physicians receive no more than 115% of the Administration's maximum allowable fees for their services and primary care physicians receive no more than 130%.

**D.** Distribution of funds. The Administration shall make annual settlements of the medical cost pool on an incurred basis. The Administration shall estimate incurred medical costs for a contract period for settlement purposes when three full months of paid claim data can be summarized following the end of the contract period. The settlement shall occur within 105 days following the end of the contract period.

**E.** The Administration reserves the right to adjust the percentage of withholding for any individual physician whose utilization rates are deemed to be excessive based on historical physician profiles.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-710 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of amended rule identical to emergency (Supp. 83-3). Former Section R9-22-710 repealed, new Section R9-22-710 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985. The capped fee-for-service schedules, deleted from Section R9-22-710, are now on file at the central office of the Administration (Supp. 85-5). Amended subsections (B) through (D) effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective July 1, 1988 (Supp. 88-3). Amended subsection (B) effective April 27, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3).

**R9-22-711. Copayments**

**A.** For purposes of this Article:

1. A copayment is a monetary amount that a member pays directly to a provider at the time a covered service is rendered.
2. An eligible individual is assigned to a hierarchy established in subsections (B) through (E), for the purposes of establishing a copayment amount.
3. A copayment is assessed prospectively. No refunds shall be made for a retroactive period if there is a change in a person's status altering the amount of a copayment.
4. Family planning services and supplies are exempt from copayments for all members.

**B.** The following individuals are exempt from all AHCCCS copayments:

1. An individual under age 19 including individuals eligible for the KidsCare Program in A.R.S. § 36-2982;
2. An individual determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services;
3. A Native American eligible under the parent program in A.R.S. § 36-2981.01;
4. A Native American enrolled with IHS;
5. An eligible individual not enrolled with a contractor and classified as fee-for-service;

6. A pregnant woman eligible for any AHCCCS program;
7. An individual eligible for the family planning services program in A.R.S. § 36-2907.04;
8. An individual eligible for the Arizona Long Term Care Program in A.R.S. § 36-2931;
9. An individual eligible for Medicare Cost Sharing in A.R.S. § 36-2972; and
10. An individual eligible for the Children's Rehabilitative Services program under A.R.S. § 36-2906(E).
11. An institutionalized person under R9-22-216.

**C.** Unless otherwise listed in subsection (B), an individual eligible for the parent program in A.R.S. § 36-2981.01 is subject to a $5.00 per visit copayment for a nonemergency use of the emergency room. A provider shall not deny service because of the member's inability to pay a copayment.

**D.** Unless otherwise listed in subsection (B) or (C), the following individuals are subject to the copayments listed in this subsection. A provider shall not deny a service because of the member's inability to pay a copayment.
1. A family eligible under Section 1931 of the Act;
2. An individual eligible for Young Adult Transitional Insurance (YATI) in A.R.S. § 36-2901(6)(iii);
3. An individual eligible for State Adoption Assistance in R9-22-1426;
4. An individual eligible for Supplemental Security Income (SSI);
5. An individual eligible for SSI Medical Assistance Only (SSI/MAO) in R9-22-1500;
6. An individual eligible for the Transitional Medical Assistance (TMA) in A.R.S. § 36-2924;
7. An individual eligible for the Freedom to Work program in A.R.S. § 36-2901(6)(g); and
8. An individual eligible for the Breast and Cervical Cancer Treatment program in A.R.S. § 36-2901.05.
9. An individual enrolled for behavioral health services in A.R.S. § 36-2907.

| Covered Services | Copayment |
|---|---|
| Physician office visit | $1.00 per office visit |
| Nonemergency use of the emergency room. | $5.00 per visit |

**E.** Unless otherwise listed in subsection (B), (C) or (D) the following individuals are required to pay the copayments listed in this subsection. The provider may deny a service if the member does not pay the required copayment.
1. An individual whose income is under 100% of the Federal Poverty Level in A.R.S. § 36-2901.01, or
2. An individual eligible for the Medical Expense Deduction program in A.R.S. § 36-2901.04.

| Covered Services | Copayment |
|---|---|
| Generic prescriptions or brand name prescriptions if generic is not available | $4.00 per prescription |
| Brand name prescriptions when generic is available | $10.00 per prescription |
| Nonemergency use of the emergency room. | $30.00 per visit |
| Physician office visit | $5.00 per office visit |

**F.** A provider is responsible for collecting any copayment.

**G.** On April 20, 2004, the United States District Court for the District of Arizona issued a preliminary injunction prohibiting enforcement of subsection (E) of this rule. For so long as the injunction is in effect, persons who would, but for the injunction, be subject to the copayment requirements and other provisions of subsection (E) shall be subject to the copayment requirements and other provisions of subsection (D).

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Sections R9-22-711 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-711 repealed, new Section R9-22-711 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by exempt rulemaking at 9 A.A.R. 4557, effective October 1, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 2194, effective May 3, 2004 (Supp. 04-2).

***Editor's Note: The following Section was adopted and amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.***

**R9-22-712. Payments by the Administration for Hospital Services**

**A.** Inpatient hospital reimbursement. The Administration shall pay for covered inpatient acute care hospital services provided to eligible persons with admissions on and after March 1, 1993, on a prospective reimbursement basis. The prospective rates shall represent payment in full, excluding quick-pay discounts, slow-pay penalties, noncategorical discounts, and third-party payments for both accommodation and ancillary department services. The rates shall include reimbursement for operating, capital, and medical education costs, as applicable. The Administration shall classify each AHCCCS inpatient hospital day of care into one of several tiers appropriate to the services rendered for payment purposes. The rate for a particular tier is referred to as the tiered per diem rate of reimbursement. Until the time of rebasing, as described in this Section, the number of tiers is seven and the maximum number of tiers payable per continuous stay is two. Payment of outlier or transplant claims or payment to out-of-state hospitals, freestanding psychiatric hospitals, rehabilitation hospitals, and other specialty facilities may differ from the inpatient hospital tiered per diem rates of reimbursement described in this Section.
1. Tier rate data. To calculate the tiered per diem rates for the initial prospective year, the Administration shall use Medicare Cost Reports for Arizona hospitals for fiscal years ending in 1990 and a database consisting of inpatient hospital claims and encounters for each hospital

with beginning dates of service for the period November 1, 1990, through October 31, 1991.

a. Medicare Cost Report data. Because Medicare Cost Report years are not standard among hospitals and were not audited at the time of the rate calculation for the initial prospective rate year, the Administration shall inflate all the costs to a common point in time as described in subsection (A)(2) for each component of the tiered per diem rates. The Administration shall not make any changes to the tiered per diem rates if the Medicare Cost Report data are subsequently updated or adjusted. If a single Medicare Cost Report is filed for more than one hospital, the Administration shall allocate the costs to each of the respective hospitals. Hospitals shall submit information to assist the Administration in this allocation.

b. Claim and encounter data. For the database, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the database was developed under A.R.S. § 36-2903.01(J). The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude claims and encounters that fail these edits from the database. The Administration may make adjustments to the data as required to correct errors. The Administration shall also exclude from the database, the following claims and encounters:
   i. Those missing information necessary for the rate calculation,
   ii. Medicare crossovers,
   iii. Those submitted by freestanding psychiatric hospitals, and
   iv. Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered per diem rate.

2. Tier rate components. The Administration shall establish inpatient hospital prospective tiered per diem rates based on the sum of the following three components: operating, capital, and medical education. The rate for the operating component shall be a statewide rate for each tier except for the ICU tier which is based on peer groups. The rate for the medical education component shall be hospital-specific. The rate for the capital component shall be a blend of statewide and hospital-specific values based upon a sliding scale until October 1, 2002. The Administration shall not include the medical education component in the tiered per diem rates if direct medical education payments are made under subsection (A)(12). The Administration shall use the following methodologies to establish the rates for each of these components and to calculate the statewide inpatient cost-to-charge ratio used for payment of outliers and out-of-state hospitals.

   a. Operating component. Using the Medicare Cost Reports and the claim and encounter database, the rate for the operating component shall be computed as follows:
      i. Data preparation. The Administration shall identify and group into department categories, the Medicare Cost Report data that provide ancillary department cost-to-charge ratios and accommodation costs per day. To comply with federal regulation, 42 CFR 447.271, the Administration shall limit cost-to-charge ratios to 1.00 for each ancillary department.
      ii. Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter database for all hospitals. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the departments in which the line items on the Medicare Cost Reports have been grouped. The ancillary department cost-to-charge ratios for a particular hospital shall be multiplied by the covered ancillary department charges on each of the hospital's claims and encounters. The AHCCCS inpatient days of care on the particular hospital's claims and encounters shall be multiplied by the corresponding accommodation costs per day from the hospital's Medicare Cost Report. The ancillary cost-to-charge ratios and accommodation costs per day shall exclude medical education and capital costs. The Administration shall inflate the resulting operating costs for the claims and encounters of each hospital to a common point in time, December 31, 1991, using the DRI inflation factor and shall reduce the operating costs for the hospital by an audit adjustment factor based on available national data and Arizona historical experience in adjustments to Medicare reimbursable costs.
      iii. Operating cost tier assignment. After calculating the operating costs, the Administration shall assign the claims and encounters used in the calculation to tiers based on diagnosis, procedure, or revenue codes, or NICU classification level, or a combination of these items. For the ICU tier, claims and encounters shall be further assigned to the urban or rural peer group. The tier rate for NICU Level II shall be calculated as 75% of the NICU Level III tier rate. For claims and encounters assigned to more than one tier, ancillary department costs shall be allocated to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component of the tiered per diem rates, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (A)(6).
      iv. Operating rate calculation. The rate for the operating component for each tier shall be set by dividing total statewide or peer group hospital costs identified in subsection (A)(2)(a) within the tier by the total number of AHCCCS inpatient hospital days of care reflected in the claim and encounter database for that tier.

   b. Medical education component.
      i. Calculation of medical education costs and component rate. The Administration shall calculate the rate for the medical education component of the tiered per diem rate on a hospital-specific basis by identifying the total direct medical education costs listed on the hospital's Medicare Cost Report. The medical education costs identified for each hospital shall reflect the medical education costs incurred by all the payors for the hospital's services, including

AHCCCS. The Administration shall reduce the medical education costs for each hospital by an audit adjustment factor based on available national data and Arizona experience in adjustments to Medicare reimbursable costs. The Administration shall divide the hospital's reduced medical education costs by the hospital's total inpatient days for all patients to yield the rate for the medical education component of the tiered per diem rate. The Administration shall inflate the medical education component to a common point in time, December 31, 1991, using the DRI inflation factor.

ii. Indexing medical education component to tiers. The Administration shall index the rate for the medical education component for each tier by the relative weighting of that tier's operating component to the operating component of all tiers. The relative weighting factor for each of the hospital's tiers shall be calculated by dividing each tier's operating component rate by the weighted average operating component rate for all tiers. The weighted average operating component rate is calculated by multiplying the operating component rate for each tier by the number of AHCCCS inpatient hospital days of care for each tier. The total of these products is then divided by the total number of AHCCCS inpatient hospital days of care for all tiers. The relative weighting factor for a tier's medical education component is multiplied by the medical education component to determine the medical education component rate for the particular tier.

iii. New medical education programs. The tiered per diem rates for hospitals with new medical education programs that are not reflected on the Medicare Cost Reports used to establish rates under this Section shall not include a medical education component until the Medicare Cost Reports used in rebasing reflect the costs of the new medical education programs. New medical education programs may be recognized prior to a rebase year at the discretion of the Director. If a hospital has an existing medical education program that is reflected in its Medicare Cost Report but has added a new medical education program that is not reflected, the hospital's tiered per diem rates shall include a rate for the medical education component that reflects only those medical education costs included in the Medicare Cost Report.

c. Capital component.

i. Structure of the capital component. During the 10-year period beginning with the initial prospective rate year, the rate for the capital component of the tiered per diem rate shall represent a blend of statewide and individual hospital capital costs in accordance with A.R.S. § 36-2903.01(J)(9). After September 30, 2002, the Administration shall combine the rate for the capital component with the rate for the operating component to produce a single statewide rate for the combination of the capital and operating components.

ii. Calculation of statewide capital costs and statewide capital component rate. The capital costs associated with inpatient hospital care shall be calculated in a manner similar to that described for operating costs in subsection (A)(2)(a)(ii). Because of the way costs are reported on the Medicare Cost Report, capital costs are derived by subtracting the costs determined when the ancillary department cost-to-charge ratios and the accommodation costs per day include only operating costs and medical education costs from the costs determined when the ancillary department cost-to-charge ratios and accommodation costs per day include capital costs as well as operating costs and medical education costs. The Administration shall inflate the resulting capital costs for each hospital to December 31, 1991, using the DRI inflation factor and shall reduce the capital costs for each hospital by an audit adjustment factor based on available national data and Arizona experience in adjustments to Medicare reimbursable costs. The statewide per day rate for capital costs shall be calculated by dividing the resulting total capital costs for all hospitals by the total AHCCCS inpatient hospital days of care reflected in the claim and encounter database.

iii. Computation of hospital-specific capital costs and hospital-specific capital component rates. The Administration shall calculate the hospital-specific capital costs per day for each hospital by dividing the capital costs identified for each hospital in subsection (A)(2)(c)(ii), as adjusted by the audit factor and inflated to December 31, 1991, by the AHCCCS inpatient hospital days of care for that hospital reflected in the claim and encounter database.

iv. Blending of capital rates. The Administration shall set the rate for the capital component by blending of the statewide and hospital-specific capital rates in accordance with the following schedule:

| PROSPECTIVE RATE YEAR | HOSPITAL SPECIFIC | STATEWIDE |
|---|---|---|
| 3/1/93-9/30/94 | 90% | 10% |
| 10/1/94-9/30/95 | 80% | 20% |
| 10/1/95-9/30/96 | 70% | 30% |
| 10/1/96-9/30/97 | 60% | 40% |
| 10/1/97-9/30/98 | 50% | 50% |
| 10/1/98-9/30/99 | 40% | 60% |
| 10/1/99-9/30/00 | 30% | 70% |
| 10/1/00-9/30/01 | 20% | 80% |
| 10/1/01-9/30/02 | 10% | 90% |
| On and after 10/01/02 | 0% | 100% |

v. Because the rate for the capital component is a blend of the statewide and hospital-specific costs, the capital component shall not be further inflated to the mid-point of the initial prospective rate year.

vi. Indexing capital component to tiers. The Administration shall index the rate for the capi-

tal component for each tier by the relative weighting of that tier's operating component to the operating component of all tiers. The relative weighting factor for each of the hospital's tiers shall be calculated by dividing each tier's operating component rate by the weighted average operating component rate for all tiers. The weighted average operating component rate is calculated by multiplying the operating component rate for each tier by the number of AHCCCS inpatient hospital days of care for each tier. The total of these products is then divided by the total number of AHCCCS inpatient hospital days of care for all tiers. The relative weighting factor for a tier's capital component is multiplied by the capital component to determine the capital component rate for the particular tier.

d. Statewide inpatient hospital cost-to-charge ratio. The statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, under subsection (A)(6). The Administration shall calculate the AHCCCS statewide inpatient hospital cost-to-charge ratio by using the Medicare Cost Report data and claim and encounter database described in subsection (A)(1) and used to determine the initial tiered per diem rates. For each hospital, the covered accommodation days on the claims and encounters shall be multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters shall be multiplied by the ancillary department cost-to-charge ratios. The accommodation costs per day and the ancillary department cost-to-charge ratios for each hospital shall be determined in the same way as described in subsection (A)(2)(a) but shall include costs for operating, capital, and medical education. The Administration shall then calculate the statewide inpatient hospital cost-to-charge ratio by summing the covered accommodation costs and ancillary department costs from the claims and encounters for all hospitals and dividing by the sum of the total covered charges for these services for all hospitals.

e. Unassigned tiered per diem rates. In the case of a hospital for which no tiered per diem rate is assigned to a tier, the Administration shall pay the statewide rate for the operating component of that tier if the hospital has qualifying claims and encounters subsequent to the base year. The rates for the capital and medical education components of a tiered per diem rate, if applicable, shall be re-weighted for a tier to which no tiered per diem rate is assigned as described in subsections (A)(2)(b) and (A)(2)(c).

3. Tier assignment. The Administration shall assign AHCCCS inpatient hospital days of care to tiers based on information submitted on the inpatient hospital claim or encounter including diagnosis, procedure or revenue codes, peer group, or NICU classification level or a combination of these items.

a. Tier hierarchy. Assignment of AHCCCS inpatient hospital days of care to a tier shall follow an ordered, hierarchical processing, as defined on the Hierarchy for Tier Assignment, which is included in subsection (J). Claims for inpatient hospital services must meet medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than two tiers, regardless of the number of interim claims that is submitted by the hospital. If a hospital changes its designation under Medicare from a rural to an urban hospital, or visa versa, the Administration shall continue to assign claims from that hospital to the rural ICU tiered per diem rate, or visa versa, until the tiered per diem rates are rebased.

b. Tier exclusions. The Administration shall not assign or pay AHCCCS inpatient hospital days of care that do not occur during an individual's eligibility period. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital cost-to-charge ratio multiplied by ancillary department and accommodation charges.

c. Seven tiers. The following seven tiers shall be in effect until the time of rebasing:

i. Maternity. The maternity tier shall be identified by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the AHCCCS inpatient hospital days of care on the claim shall be paid the maternity tiered per diem rate.

ii. NICU. The NICU tier shall be identified by a revenue code. For a hospital to qualify for the NICU tiered per diem rate, the hospital must be classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. Among AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier, those with an NICU revenue code shall be paid at the NICU tiered per diem rate. Any remaining AHCCCS inpatient hospital day or days on the claim not meeting NICU Level II or NICU Level III medical review criteria shall be paid at the nursery tiered per diem rate.

iii. ICU. The ICU tier shall be identified by a revenue code. Among AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the ICU tier, those with an ICU revenue code shall be paid at the ICU tiered per diem rate. If there are any AHCCCS inpatient hospital days on the claim without an ICU revenue code, they may be classified as surgery, psychiatric, or routine tiers.

iv. Surgery. The surgery tier shall be identified by a revenue code in combination with a valid surgical procedure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list shall identify minor procedures such as sutures that do not require the same hospital resources as other procedures. A surgery claim may also have AHCCCS inpatient hospital days of care at the ICU tier. AHCCCS shall pay the surgery tier only when the surgery occurs on a date during which the member is eligible.

v. Psychiatric. The psychiatric tier shall be identified by either: a psychiatric revenue code and a psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. A claim with AHCCCS inpatient hospital days of care in the psychiatric tier may split only with the ICU tier.

vi. Nursery. The nursery tier rate shall be identified by a revenue code. A claim with AHCCCS inpatient hospital days of care in the nursery tier may split only with the NICU tier.

vii. Routine. The routine tier shall be identified by particular revenue codes and shall include AHCCCS inpatient hospital days of care that are not otherwise classified into the proceeding tiers or paid in accordance with subsection (A)(11). The routine tier may split only with the ICU tier.

4. Annual update. After the initial prospective rate year and between rebasing years, the Administration shall annually update the inpatient hospital tiered per diem rates in accordance with A.R.S. § 36-2903.01(J)(2) and (J)(9) as follows:
   a. Inflation factor. The rates for the operating and medical education components of the tiered per diem rate shall be inflated to the midpoint of the prospective rate year, using the DRI inflation factor.
   b. Length of stay adjustment. The rate for the operating component of the tiered per diem rate shall be adjusted for any change in the statewide average length of stay for eligible persons. The change in length of stay shall be computed each year by comparing the average length of stay for each tier based on claims and encounters to the average length of stay for each tier calculated in the previous year. The operating component of the tiered per diem rates shall be adjusted by the percentage change in length of stay. If the length of stay increases for a tier, the rate for the operating component shall be adjusted downward. If the length of stay decreases for a tier, the rate for the operating component shall be adjusted upward. Except for the first annual update of the initial prospective rate year, the Administration shall use claims and encounters that are from the federal fiscal year period beginning two years before the prospective rate year that is being updated. For the annual update for the prospective rate year beginning October 1, 1996, the claims and encounters with beginning dates of service from October 1, 1994, to September 30, 1995 shall be used for making any length of stay adjustment. For the annual update of the initial prospective rate year, the Administration shall use claims and encounters with beginning dates of service from March 1, 1993, to September 30, 1993. The Administration shall subject the claim and encounter data to the same data edits described in subsection (A)(1)(b). Outliers shall be excluded as identified in subsection (A)(6)(a).
   c. Capital component update. For the capital component of the tiered per diem rate, the Administration shall adjust the hospital-specific and statewide average blend described in subsection (A)(2)(c). The Administration shall adjust the hospital-specific part of the capital component by using the capital costs from the hospital's subsequent Medicare Cost Report. The Medicare Cost Report used for the first update is FY1991. The percentage change in the capital costs per day, as shown on the hospital's Medicare Cost Report from one year to the next, shall be applied to the hospital-specific part of the capital component. The Administration shall recalculate the statewide average part of the capital component based on the percentage change in hospital-specific capital costs. The percentage change shall be limited to the initial prospective rate year statewide capital costs increased by the DRI inflation factor. The Administration shall adjust the rate for the capital component of the tiered per diem downward, if after the update, the statewide average rate of the capital component as a percent of the statewide average total tiered per diem rate exceeds the percentage of the statewide average capital costs to the total statewide average inpatient hospital costs used in calculating the tiered per diem rates for the initial prospective rate year.
5. New Hospitals. The Administration shall calculate the tiered per diem rates for new hospitals differently than the tiered per diem rates for hospitals for which Medicare Cost Reports and claims and encounters were used to establish the tiered per diem rates for the initial prospective rate year or for a rebase year. The tiered per diem rates paid to a new hospital shall be the sum of the operating and capital components. The rate for the operating component for a new hospital shall be the same as the rate for the operating component established in subsection (A)(2)(a). The rate for the capital component for a new hospital shall equal the statewide average rate for the capital component as described in subsection (A)(2)(c)(ii) and shall vary by tier based on an index that represents the statewide relative weight of each tier's operating component to the operating component of all tiers. The tiered per diem rates for new hospitals shall not include a medical education component. The annual update shall be applied to a new hospital's rates for its operating and capital components, except hospital-specific capital costs shall not be considered as described in subsection (A)(2)(c)(iii).
6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers in accordance with this Section by multiplying the cover charges on a claim by the statewide inpatient hospital cost-to-charge ratio.
   a. Outlier criteria. For the initial prospective rate year, the Administration shall set the statewide outlier cost threshold for each tier at the greater of three standard deviations from the statewide mean operating cost per day within the tier, or two standard deviations from the statewide mean operating cost per day across all the tiers. Because hospitals submit charges, rather than costs, on claims and encounters, the Administration sets hospital-specific charge thresholds by dividing the statewide outlier cost threshold for each tier by the hospital's inpatient operating cost-to-charge ratio. If the covered charges per day on a claim or encounter exceed the hospital-specific charge threshold for a tier, the claim or encounter shall be considered an outlier. If there are two tiers on a claim or encounter, the Administration shall determine whether the claim or encounter is an outlier by using a weighted threshold for the two tiers. The weighted threshold is calculated by multi-

plying each tier rate by the number of AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital.

b. Update. The Administration shall update the outlier cost thresholds and outlier charge thresholds for each hospital. The outlier cost thresholds are updated annually by recalculating the standard deviations based on the claims and encounters used for the length-of-stay adjustment described in subsection (A)(4)(b). The outlier charge thresholds are updated as defined in subsection (A)(6)(a). Claims and encounters exceeding the updated outlier cost thresholds will be excluded for purposes of calculating the change in length-of-stay. The Administration shall estimate the operating cost of claims and encounters based on the application of an inpatient hospital-specific operating cost-to-charge ratio.

7. Transplants. The Administration shall reimburse hospitals for an AHCCCS inpatient stay in which a covered organ transplant is performed through the terms of a relevant contract agreement. Pursuant to R9-22-716, if the Administration and a hospital that performs a transplant surgery on an eligible person do not have a contracted rate, the system shall not reimburse the hospital more than the contracted rate established by the Administration.
8. Rebasing. The Administration shall rebase the tiered per diem rates by the prospective rate year beginning October 1, 1998. The rebasing process shall include the following:
   a. Rebasing data. The Administration shall use a hospital's Medicare Cost Report for a fiscal year ending at least two years before the prospective rate year in which the rebase is to begin. For example, for the rebase year of October 1, 1998, the Medicare Cost Reports would be for hospital fiscal years ending in 1996, or earlier. The Administration shall follow the procedures described in subsection (A)(1)(a) for Medicare Cost Report data, except that costs shall be inflated to December 31 of the fiscal year applicable to the Medicare Cost Report year, and a new audit factor shall be derived by the Administration based on available national and Arizona data. To calculate the rebased tiered per diem rates, the Administration may use the ancillary department or line item cost-to-charge ratios from the Medicare Cost Report. In addition for each hospital, the Administration shall use a database consisting of inpatient hospital claims and, if appropriate, encounters with beginning dates of service covered by the hospital's respective Medicare Cost Report reporting period. Claims and encounters included in the database will be those available at the time of rebasing that pass the Administration's data quality, reasonableness, and integrity edits described in subsection (A)(1)(b). The Administration shall exclude or adjust the claims or encounters that do not meet the medical review criteria at R9-22-717 and R9-22-209(C).
   b. Rebasing components. The rebased tiered per diem rates shall include rates for the following two components: operating and capital. The Medical education component shall be included unless direct medical education is reimbursed under subsection (A)(12). The Administration shall follow the methodology described in subsection (A)(2) to establish the rebased rates for each of the components. However, during the rebasing process the Administration shall re-examine the current tier structure and may adopt an alternative structure, hierarchy, or number of tiers if analyses conducted by the Administration indicate that an alternative or alternatives is or are appropriate. The Administration shall add cost containment features at the time of rebasing.
   c. Rebasing peer groups for the operating component. To rebase the rate for the operating component of the tiered per diem rate, the Administration shall re-analyze whether the operating component shall be peer grouped according to such factors as geographical location or major teaching versus non-major teaching hospital.
   d. Rebasing the capital component. The capital component of the tiered per diem rate shall be a blend of statewide and hospital-specific capital costs pursuant to subsection (A)(2)(c). The Administration shall adjust the rate for the capital component of the tiered per diem rate downward if after rebasing the statewide average rate for the capital component as a percent of the statewide average total tiered per diem rate exceeds:
      i. The percentage of the statewide average capital costs to the total statewide average inpatient hospital costs used in calculating the tiered per diem rates for the initial prospective rate year; or
      ii. The most recently available national average percentage of capital costs to total inpatient hospital costs.
      iii. The adjustment to the rate for the capital component shall be based on the lesser of subsection (i) or (ii).
   e. Rebasing outliers. Depending on the payment methodology adopted at the time of rebasing, the Administration may not include provisions for payment of outliers.
   f. Psychiatric and rehabilitation hospitals. At the time of rebasing, the Administration shall re-examine the basis of payment for freestanding rehabilitation and psychiatric hospitals. If the decision is made to continue to reimburse these hospitals according to the methodology described in subsection (A)(10), the Administration shall exclude the claims and encounters from these hospitals that are not paid by the tiered per diem reimbursement system.
   g. Data required. Beginning with fiscal years ending in 1996, hospitals shall file with the Administration all Medicaid-specific schedules of the Medicare Cost Report at the time the Medicare Cost Report is submitted to the Medicare Intermediary as required in A.R.S. § 36-125.04.
9. Ownership change. A hospital shall not receive a change in any of the components of the hospital's tiered per diem rates upon an ownership change.
10. Psychiatric and rehabilitation hospitals. The Administration shall pay freestanding psychiatric hospitals an all-inclusive per diem rate based on the contracted rates used by the Department of Health Services and shall pay freestanding rehabilitation hospitals the rate for the operating component of the routine tiered per diem rate plus the rates for the capital and medical education components as appropriate or an all-inclusive per diem rate that is negotiated by the Administration.

11. Specialty facilities. The Administration may negotiate, at any time, reimbursement rates for inpatient specialty facilities or inpatient hospital services not otherwise addressed in this Section as provided by A.R.S. § 36-2903.01(J)(1).
12. Direct medical education payments. Instead of including a direct medical education component in the tiered per diem rates, the Administration may reimburse hospitals directly for the hospital's costs associated with direct medical education. In this case, the Administration shall not continue to calculate direct medical education costs using the methodology described in subsection (A)(2)(b)(i), and shall not update direct medical education payments in accordance with subsection (A)(4).

**B.** Outpatient hospital reimbursement. The Administration shall pay for covered outpatient hospital services provided to eligible persons on and after March 1, 1993, at the AHCCCS outpatient hospital cost-to-charge ratio, multiplied by the covered charges.

1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs shall be included in the computation but outpatient medical education costs that are included in the inpatient medical education component shall be excluded. To calculate the outpatient hospital cost-to-charge ratio for the initial prospective rate year for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in subsections (A)(1)(a) and (A)(1)(b). The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:
    a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters for outpatient hospital services. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
    b. Cost-to-charge limit. To comply with federal regulation, 42 CFR 447.325, the Administration may limit cost-to-charge ratios at 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are noncovered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.
2. New hospitals. The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost-to-charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in specialty facilities.
4. Reimbursement requirements. To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than 0. The Administration shall not reimburse hospitals for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis, as described in subsection (B), if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation, or other outpatient department. The emergency room, observation, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment.
5. Rebasing. The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every one to four years using updated Medicare Cost Reports and claim and encounter data.

**C.** Discounts and penalties. The Administration shall subject all inpatient hospital admissions and outpatient hospital services on and after March 1, 1993, to quick-pay discounts and slow-pay penalties in accordance with Laws 1992, Ch. 302, § 14, as amended by Laws 1993, 2nd S.S., Ch. 6, § 27; Laws 1995, 1st Special Session, Ch. 5, § 6 and A.R.S. § 36-2903.01(J)(6).

**D.** Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall not withhold access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or its designated representative in performance of the Administration's utilization control activities. Failure to cooperate may result in denial or non-payment of claims.

**E.** Prior authorization. Failure to obtain prior authorization required by R9-22-210 shall be cause for denial or nonpayment of claims.

**F.** Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers to prepayment medical review, or post-payment review or both by the Administration. Post-payment reviews shall be consistent with A.R.S. § 36-2903.01(O) and erroneously paid claims are subject to recoupment. If prior authorization was given for a specific level of care but medical review of the claim indicates that a different level of care was appropriate, the Administration may adjust the claim to reflect the more appropriate level of care, which shall be effective on the date when the different level of care was medically appropriate.

**G.** Claim receipt. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the claim reference number. Hospital claims will be considered paid on the date indicated on disbursement checks. Denied claims will be considered adjudicated on the date of their denial. Claims that are denied and are resubmitted will receive new date stamps. Claims that are pending for additional supporting documentation from hospitals will receive new date stamps upon receipt of the additional documentation, except as provided under R9-22-717. Claims that pend for additional supporting documentation shall not be counted in the calculation of the quick-pay discounts and slow-pay penalties pursuant to R9-22-712 (C). For purposes of this subsection, the time-

frames for submitting claims and the definition of a clean claim are consistent with A.R.S. § 36-2904.

**H.** Out-of-state hospital payments. The Administration shall pay for covered hospital services provided to eligible persons by out-of-state hospitals at negotiated discounted rates, the statewide average inpatient or outpatient cost-to-charge ratio multiplied by covered charges or, if reasonably and promptly available, the Medicaid rate that is in effect at the time services are provided in the state in which the hospital is located, whichever is lowest.

**I.** Prior period payments. The Administration shall pay for covered hospital services, provided to eligible persons with inpatient hospital admissions and outpatient hospital services before March 1, 1993, pursuant to R9-22-706.

**J.** Hierarchy For Tier Assignment.

| TIER | IDENTIFICATION CRITERIA | ALLOWED SPLITS |
|---|---|---|
| MATERNITY | A primary diagnosis defined as maternity 640.xx - 643.xx, 644.2x - 676.xx, v22.xx - v24.xx or v27.xx. | None |
| NICU | Revenue Code of 175 for DOS before 10/1/95 AND the provider has a Level II or Level III NICU, or Revenue Code of 174 for DOS on, or after 10/1/95 AND the provider has a Level II or Level III NICU. | Nursery |
| ICU | Revenue Codes of 200-204, 207-212, or 219. | Surgery Psychiatric Routine |
| SURGERY | Surgery is identified by a revenue code of 36x. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list. | ICU |
| PSYCHIATRIC | Psychiatric Revenue Codes of 114, 124, 134, 144, or 154 AND Psychiatric Diagnosis = 290.xx - 316.xx. If a routine revenue code is present and all diagnoses codes on the claim are equal to 290.xx - 316.xx, classify as a psychiatric claim. | ICU |
| NURSERY | Revenue Code of 17x, not equal to 175 or 174. | NICU |
| ROUTINE | Revenue Codes of 100 - 101, 110-113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16x, 206, 213, or 214. | ICU |

**Historical Note**

Adopted as an emergency effective February 23, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to emergency (Supp. 83-3). Former Section R9-22-712 repealed, new Section R9-22-712 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-712 renumbered and amended as Section R9-22-1001 effective October 1, 1985 (Supp. 85-5). New Section R9-22-712 adopted under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective January 14, 1997 (Supp. 97-1).

**R9-22-713. Payments Made on Behalf of a Contractor; Recovery of Indebtedness**

**A.** The Administration may make payments on behalf of a contractor in order to prevent a suspension or termination of AHCCCS services after considering whether:
1. A contractor does not adjudicate a valid accrued claim within the period set forth under subcontract, or
2. A contractor does not adjudicate 99 percent of valid accrued claims within 90 days of receipt from the AHCCCS registered provider.

**B.** If a contractor or a subcontracting provider receives an overpayment from the Administration or otherwise becomes indebted to the Administration, the contractor or subcontracting provider shall immediately the amount of the indebtedness or overpayment to the Administration for deposit in the AHCCCS fund.

**C.** If the funds described in subsection (B) are not remitted, the Administration may recover the indebtedness or overpayment paid by the Administration to a contractor or subcontracting provider through:
1. Negotiation of a repayment agreement executed with the Administration;
2. Withholding or offsetting against current or future payments to be paid to the contractor or subcontracting provider; or
3. Enforcement of, or collection against, the performance bond, financial reserve, or other financial security under A.R.S. § 36-2903.

**D.** Except as specifically provided for in this Article, the Administration is not liable for payment for medical expenses incurred by enrolled members of prepaid capitated contractors.

**Historical Note**

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to the emergency (Supp. 83-3). Former Section R9-22-713 repealed, new Section R9-22-713 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-713 renumbered and amended as Section R9-22-714, former Section R9-22-709 renumbered and amended as Section R9-22-713 effective October 1, 1985 (Supp. 85-5). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3).

**R9-22-714. Payments to Providers**

**A.** Provider agreement. The Administration or a contractor shall not reimburse a covered service provided to a member unless the provider has signed a provider agreement with the Administration that establishes the terms and conditions of participation and payment under A.R.S. § 36-2904.

**B.** Provider reimbursement. The Administration or a contractor shall reimburse a provider for a service furnished to a member only if:
1. The provider personally furnishes the service to a specific member,
2. The service contributes directly to the diagnosis or treatment of a specific member, and
3. The service ordinarily requires performance by the type of provider seeking reimbursement.

**C.** Reimbursement for a pathology service. Unless otherwise specified in a contract, the Administration or a contractor shall reimburse a pathologist for a pathology service furnished to a

member only if the other requirements in this Section are met and the service is:

1. A surgical pathology service;
2. A specific cytopathology, hematology, or blood banking pathology service that requires performance by a physician and is listed in the capped fee-for-service schedule;
3. A clinical consultation service that:
   a. Is requested by the member's attending physician or primary care physician,
   b. Is related to a test result that is outside the clinically significant normal or expected range in view of the condition of the member,
   c. Results in a written narrative report included in the member's medical record,
   d. Requires the exercise of medical judgment by the consultant pathologist, and
   e. Is listed in the capped fee-for-service schedule; or
4. A clinical laboratory interpretative service that:
   a. Is requested by the member's attending physician or primary care physician,
   b. Results in a written narrative report included in the member's medical record,
   c. Requires the exercise of medical judgment by the consultant pathologist, and
   d. Is listed in the capped fee-for-service schedule.

**Historical Note**

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule is similar to the emergency (Supp. 83-3). Repealed effective October 1, 1983 (Supp. 83-5). Former Section R9-22-713 renumbered and amended as Section R9-22-714 effective October 1, 1985 (Supp. 85-5). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 9 A.A.R. 3800, effective October 4, 2003 (Supp. 03-3).

***Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.***

**R9-22-715. Hospital Rate Negotiations**

**A.** Effective for inpatient hospital admissions and outpatient hospital services on or after March 1, 1993, contractors that negotiate with hospitals for inpatient or outpatient services shall reimburse hospitals for member care based on the prospective tiered-per-diem amount, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges in A.R.S. § 36-2903.01 and R9-22-712, or the negotiated rate that, when considered in the aggregate with other hospital reimbursement levels, does not exceed what would have been paid under A.R.S. § 36-2903.01 and R9-22-712. This subsection does not apply to hospitals participating in the pilot program under R9-22-718.

1. Contractors may engage in rate negotiations with hospitals at any time during the contract period.
2. Within seven days of the completion of the agreement process, contractors shall submit copies of their negotiated rate agreements, including all rates, terms, and conditions, with hospitals to the Administration for approval. Contractors shall demonstrate to the Administration that the effect of their negotiated rate agreement will, when considered in the aggregate, be the same as or produce greater dollar savings than would have been paid under A.R.S. § 36-2903.01 and R9-22-712.
   a. To demonstrate the aggregate effect of its negotiated rate agreement, contractors shall present their assumptions related to projected utilization of various hospitals to the Administration. The contractor may consider inpatient assumptions related to:
      i. Member mix;
      ii. Admissions by AHCCCS-specified tiers;
      iii. Average length of stay by tier and pattern of admissions, excluding emergency admissions;
      iv. Outliers; and
      v. Risk-sharing arrangements.
   b. The contractor also may consider outpatient assumptions related to member mix and outpatient service utilization. The Administration reserves the right to approve, deny, or require mutually-agreed-to modifications of these assumptions.
   c. When a contractor adjusts or modifies an assumption, the reason for the adjustment or modification shall be presented to the Administration, as well as the new assumption. The Administration may approve, deny, or require mutually-agreed-to modification of an assumption.
   d. To determine whether a negotiated rate agreement produces reimbursement levels that do not in the aggregate exceed what would be paid under A.R.S. § 36-2903.01 and R9-22-712, a contractor shall require its independent auditors to evaluate the reasonableness of its assumptions as part of its annual audit. The contractor shall ensure that its independent auditor's audit program is consistent with AHCCCS audit requirements and is submitted to the Administration for prior approval.
   e. Negotiated inpatient or outpatient rate agreements with hospitals with a contractor has a related-party interest are subject to additional related party disclosure and evaluation. These evaluations are in addition to the procedures described in subsection (A)(2)(c) and shall be performed by the contractor's independent auditors, or, at the contractor's option, by the Administration.
   f. The Administration shall subject a contractor's independent auditor's report to any examination or review necessary to ensure accuracy of all findings related to aggregate rate determinations.
   g. The Administration shall use its standards, consistent with the Request for Proposals and R9-22-502, to determine whether a contractor's inpatient or outpatient hospital subcontractors will limit the availability or accessibility of services. The Administration reserves the right to reject hospital subcontracts that limit the availability or accessibility of services.

**B.** The Administration may negotiate or contract with a hospital on behalf of a contractor for discounted hospital rates and may require that the negotiated discounted rates be included in a subcontract between the contractor and hospital.

**C.** The Director shall apportion any cost avoidance in the hospital component of provider capitation rates between the Administration and provider. The Administration's portion of the cost avoidance shall be reflected in reduced capitation rates paid to providers.

**Historical Note**
Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to the emergency (Supp. 83-3). Repealed effective October 1, 1983 (Supp. 83-5). New Section R9-22-715 adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective January 14, 1997 (Supp. 97-1). Amended effective September 22, 1997 (Supp. 97-3).

***Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.***

**R9-22-716. Specialty Contracts**
The Director may contract with entities for specialized hospital and medical services including:
1. Neonatology,
2. Neurology,
3. Cardiology,
4. Burn care under A.R.S. § 36-2903.01, and
5. Transplant services.

**Historical Note**
Adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-717. Hospital Claims Review**
**A.** The Administration and its contractors shall review hospital claims that are timely received as specified in R9-22-703(B).
**B.** A charge for hospital services provided to an eligible person during a time when the eligible person was not the financial responsibility of the Administration shall be denied.
**C.** Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
1. Patient care kit,
2. Toothbrush,
3. Toothpaste,
4. Petroleum jelly,
5. Deodorant,
6. Septi soap,
7. Razor,
8. Shaving cream,
9. Slippers,
10. Mouthwash,
11. Disposable razor,
12. Shampoo,
13. Powder,
14. Lotion,
15. Comb, and
16. Patient gown.

**D.** The following hospital supplies and equipment, if medically necessary and used, are covered services:
1. Arm board,
2. Diaper,
3. Underpad,
4. Special mattress and special bed,
5. Gloves,
6. Wrist restraint,
7. Limb holder,
8. Disposable item used in lieu of a durable item,
9. Universal precaution,
10. Stat charge, and
11. Portable charge.

**E.** The hospital claims review shall determine whether services rendered were:
1. AHCCCS-covered services;
2. Medically necessary;
3. Provided in the most appropriate, cost-effective, least restrictive setting; and
4. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2903.01(J) or 36-2904(K), whichever is applicable.

**F.** If a claim is denied by either the Administration or its contractor, a grievance challenging the denial may be filed against the entity denying the claim. The grievance shall be filed no later than 12 months from the date of service, 12 months from the date of eligibility posting, or 35 days from the date of notice of adverse action, whichever is latest. Any grievance challenging a postpayment review recoupment action shall be filed by the provider no later than 12 months from the date of service, 12 months from the date of eligibility posting, or 35 days from the date of the notice of recoupment, whichever is latest.

**Historical Note**
Adopted effective July 30, 1993 (Supp. 93-3). Amended effective September 22, 1997 (Supp. 97-3).

***Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council. The agency was required to submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and was required to hold a public hearing.***

**R9-22-718. Urban Hospital Inpatient Reimbursement Program**
**A.** Definitions. The following definitions apply to this Section:
1. "Noncontracted Hospital" means an urban hospital which does not have a contract under this Section with an urban contractor in the same county.
2. "Rural Contractor" means a contractor or program contractor as defined in A.R.S. Title 36, Chapter 29 that does not provide services to members residing in either Maricopa or Pima County.
3. "Urban Contractor" means a contractor or program contractor as defined in A.R.S. Title 36, Chapter 29, that provides services to members residing in Maricopa or Pima County and may also provide services to members who reside in other counties. An urban contractor does not include BHS, CRS, CMDP, HCG or a Tribal government.
4. "Rural Hospital" means a hospital, as defined in Article 1, that is physically located in Arizona but in a county other than Maricopa and Pima County.
5. "Urban Hospital" means a hospital, as defined in Article 1, that is physically located in Maricopa or Pima County.

**B.** General Provisions.
1. This Section applies to an urban hospital who receives payment for inpatient hospital services under A.R.S. §§ 36-2903.01 and 36-2904.

2. AHCCCS shall operate an inpatient hospital reimbursement program under A.R.S. § 36-2905.01 and this Section.
3. Residency of the member receiving inpatient AHCCCS covered services is not a factor in determining which hospitals are required to contract with which contractors.
4. An urban contractor shall enter into a contract for reimbursement for inpatient AHCCCS covered services with one or more urban hospitals located in the same county as the urban contractor.
5. A noncontracted urban hospital shall be reimbursed for inpatient services by an urban contractor based on the tiered per diem rates for that hospital as defined in A.R.S. § 36-2903.01 and R9-22-712, multiplied by 95% unless otherwise negotiated by both parties.

**C.** Contract Begin Date. A contract under this Article shall cover inpatient acute care hospital services for members with hospital admissions on and after October 1, 2003.

**D.** Outpatient urban hospital services. Outpatient urban hospital services, including observation days and emergency room treatments that do not result in an admission, shall be reimbursed either through an urban hospital contract negotiated between a contractor and an urban hospital, or the reimbursement rates set forth in A.R.S. § 36-2903.01. Outpatient services in an urban hospital that result in an admission shall be paid as inpatient services in accordance with this Section.

**E.** Urban Hospital Contract.
1. Provisions of an urban hospital contracts. The urban hospital contract shall contain but is not limited to the following provisions:
   a. Required provisions as described in the Request for Proposals (RFP);
   b. Dispute settlement procedures. If the AHCCCS Grievance System prescribed in A.R.S. § 36-2903.01(B) and rule is not used, then arbitration shall be used.
   c. Arbitration procedure. If arbitration is used, the urban hospital contract shall identify:
      i. The parties' agreement on arbitrating claims arising from the contract,
      ii. Whether arbitration is nonbinding or binding,
      iii. Timeliness of arbitration,
      iv. What contract provisions may be appealed,
      v. What rules will govern arbitrations,
      vi. The number of arbitrators that shall be used,
      vii. How arbitrators shall be selected, and
      viii. How arbitrators shall be compensated.
   d. Timeliness of claims submission and payment;
   e. Prior authorization;
   f. Concurrent review;
   g. Electronic submission of claims;
   h. Claims review criteria;
   i. Payment of discounts or penalties such as quick-pay and slow-pay provisions;
   j. Payment of outliers;
   k. Claim documentation specifications under A.R.S. § 36-2904.
   l. Treatment and payment of emergency room services; and
   m. Provisions for rate changes and adjustments.
2. AHCCCS review and approval of urban hospital contracts.
   a. AHCCCS may review, approve, or disapprove the hospital contract rates, terms, conditions, and amendments to the contract.
   b. An urban contractor shall submit urban hospital contracts and amendments as specified in the RFPs for the contract year beginning October 1, 2003, or as specified in the RFP for a new urban hospital contract negotiated after October 1, 2003.
   c. The AHCCCS evaluation of each urban hospital contract shall include but not be limited to the following areas:
      i. Availability and accessibility of services to members,
      ii. Related party interests,
      iii. Inclusion of required terms pursuant to this Section, and
      iv. Reasonableness of the rates.
3. Evaluation of urban contractor's use of a noncontracted hospital. AHCCCS shall evaluate the contractor's use of a contracted versus noncontracted hospital.

**F.** Outlier Policy. When there is no hospital contract between an urban contractor and an urban hospital, reimbursement of an outlier is based upon the effective FFS outlier thresholds at 95% of the statewide average cost-to-charge ratio in effect.

**G.** Quick-Pay/Slow-Pay. A payment made by urban contractor to a noncontracted hospital shall be subject to quick-pay discounts and slow-pay penalties under A.R.S. § 36-2904.

**Historical Note**
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective January 29, 1997; pursuant to Laws 1996, Ch. 288, § 24 (Supp. 97-1). Amended by exempt rulemaking at 10 A.A.R. 500, effective February 1, 2004 (Supp. 04-1).

**R9-22-719. Contractor Performance Measure Outcomes**
The Administration may retain a specified percentage of capitation reimbursement to distribute to contractors based on their performance measure outcomes under A.R.S. § 36-2904. The Administration shall notify contractors 60 days prior to a new contract year if this methodology is implemented. The Administration shall specify the details of the reimbursement methodology in contract.

**Historical Note**
New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-720. Reinsurance**

**A.** For purposes of the Administration's reinsurance program, the insured entity is a prepaid plan with which the Administration contracts. The Administration shall specify in contract guidelines for claims submission, processing, and payment and the types of care and services that are provided to a member whose care is covered by reinsurance.

**B.** When the Administration determines that a contractor does not follow the specified guidelines for care or services and the care or services could be provided at a lower cost according to the guidelines, the contractor is entitled to reimbursement as if the care or services specified in the guidelines had been provided at a lower cost.

**Historical Note**
New Section made by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3).

**ARTICLE 8. REPEALED**

*Article 8, consisting of Sections R9-22-801 through R9-22-804 and Exhibit A, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).*

**R9-22-801. Repealed**

**Historical Note**
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-801 adopted as an emergency adoption now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-801 repealed, new Section R9-22-801 adopted effective October 29, 1985 (Supp. 85-5). Amended subsections (C), (F), (H), (I), and (K) effective October 1, 1986 (Supp. 86-5). Change of heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (H) effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Section heading amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-801 repealed, new Section R9-22-801 adopted January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-802. Repealed**

**Historical Note**
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-802 adopted as an emergency adoption now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 29, 1985 (Supp. 85-5). Amended subsections (A), (B), (C) and (D) effective October 14, 1988 (Supp. 88-4). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-802 repealed, new Section R9-22-802 adopted effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-803. Repealed**

**Historical Note**
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-803 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-803 repealed, new Section R9-22-803 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-803 renumbered and amended as Section R9-22-804. Adopted effective January 31, 1986 (Supp. 86-1). Amended effective September 29, 1992 (Supp. 92-3). Former Section R9-22-803 repealed, new Section R9-22-803 adopted January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-804. Repealed**

**Historical Note**
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-804 adopted as an emergency adoption now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Former Section R9-22-804 repealed, former Section R9-22-803 renumbered and amended as Section R9-22-804 effective October 29, 1985 (Supp. 85-5). Amended effective October 14, 1988 (Supp.88-4). Amended subsections (B) and (C) effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-804 repealed, new Section R9-22-804 adopted effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**Exhibit A. Repealed**

**Historical Note**
New Exhibit adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Exhibit repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-805. Repealed**

**Historical Note**
Former Section R9-22-805 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective January 31, 1986 (Supp. 86-1).

## ARTICLE 9. QUALITY CONTROL

**R9-22-901. General Information**

**A.** This Article defines the responsibilities, structure, and requirements of the Medicaid Eligibility Quality Control program (MEQC) which are further delineated in the Intergovernmental Agreement (IGA) under A.R.S. § 36-2903.01 between the Administration and the Department.

**B.** The Administration conducts MEQC activities to:
1. Determine the Department's compliance with the IGA,
2. Prevent or detect an eligibility error, and
3. Determine compliance with performance measures.

**C.** The Administration shall select cases, under Sections R9-22-903 through R9-22-905, for review on a monthly basis from eligibility determinations made in the previous month within each six-month review period. Each six-month review period sample will be statistically valid at 95 percent confidence level on a statewide or district basis in accordance with AHCCCS' Quality Control Redesign Pilot as approved by CMS.

**Historical Note**
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-901 adopted as an emergency adoption now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective August 29, 1985 (Supp. 85-4). Amended effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at

5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-902. Pre-Determination Quality Control (PDQC)**

**A.** The Department shall screen Title XIX applications, provide PDQC referrals to the Administration, and comply with the PDQC requirements.

**B.** The Administration may conduct a case review prior to a determination of eligibility in order to avoid an error and prevent fraud.

**C.** The Department shall compare the Administration's review findings with information received during and after an interview under Article 14 and with previous applications to determine whether or not an individual or family is eligible based on a preponderance of evidence.

**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-902 renumbered and amended as Section R9-22-904, former Section R9-22-903 renumbered and amended as Section R9-22-902 effective October 1, 1986 (Supp. 86-5). Former Section R9-22-902 repealed, new Section R9-22-902 adopted effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-903. Random Sample**

**A.** The Administration shall select a case from a statistically valid random sample of all cases approved or active for Title XIX during a review period, conduct a case review, and issue a Notice of Finding to the Department.

**B.** The Administration may stratify cases by district.

**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-903 renumbered and amended as Section R9-22-902, former Section R9-22-904 renumbered and amended as Section R9-22-903 effective October 1, 1986 (Supp. 86-5). Former Section R9-22-903 repealed, new Section R9-22-903 adopted effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-904. Targeted Sample**

**A.** The Administration may conduct a targeted case review based on specific criteria and issue a Notice of Finding to the Department.

**B.** The Administration shall select a sample for a targeted review either on a random basis or on an individual case basis. The criteria may be by case characteristics, individual office or district, or other criteria determined by the Administration.

**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-904 renumbered and amended as Section R9-22-903, former Section R9-22-902 renumbered and amended as Section R9-22-904 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-905. Negative Case Action Sample**

**A.** The Administration shall select a case from a statistically valid random sample of all cases denied or discontinued from Title XIX during a review period, conduct a case review, and issue a Notice of Finding to the Department.

**B.** The Administration may stratify cases by district.

**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-905 renumbered without change as Section R9-22-908, former Section R9-22-907 renumbered and amended as Section R9-22-905 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-906. Management Evaluation Review**

**A.** The Administration shall perform a Management Evaluation Review of the Department under A.R.S. § 36-2903.01 to determine whether the performance measures are being met and include any findings in the Summary Report to the Department. No less than 12 Department eligibility sites will be reviewed annually.

**B.** The Management Evaluation Reviews may include:

1. Interviews with applicants, members and Department staff,
2. Observation of local office practices,
3. Reviews of notices sent to an applicant and a member,
4. Reviews of pre-enrollment procedures,
5. Other areas of the eligibility process for which the Department is responsible,
6. The eligibility appeal process, or
7. Interviews with department staff located in or staff employed by Federally Qualified Health Centers and Level One Trauma Centers to identify any barriers, including sufficient staffing, that delay the processing of applications.

**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Amended effective October 1, 1986 (Supp. 86-5). Amended effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-907. Challenge of Findings**

**A.** Challenge Process.

1. The Department may challenge the Administration's error finding under R9-22-903 through R9-22-905 by submitting a written challenge to the Administration. The Administration shall receive the challenge no later than 15 days from the date of the Notice of Finding. The date of the Notice of Finding is the date the Notice is mailed.
2. The Department shall include evidence that refutes an error finding. The Department may include in its written

challenge evidence obtained after the date of the Notice of Finding.

3. The Administration's finding shall be final if the Department fails to submit a challenge under the time-frame in subsection (A)(1).

**B.** Administration Decision.

1. The Administration shall review, within 30 days of receipt, the Department's challenge of an error finding and either uphold or overturn a finding.
2. The Administration shall overturn an error finding if a preponderance of the evidence establishes that the Department's decision was not an error.
3. The Administration shall not consider a case an error in calculating the Department's error rate under R9-22-909(A) if the Administration overturns a finding.
4. The Department may file a grievance under Article 8 concerning the Administration's decision.

**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-907 renumbered and amended as Section R9-22-905, former Section R9-22-908 renumbered and amended as Section R9-22-907 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-908. Corrective Action Plans**

**A.** The Administration shall issue a Summary Report to the Department following the completion of each review period.

**B.** The Department shall prepare and implement a corrective action plan if the Summary Report identifies an error rate greater than the tolerance level either statewide or by district or the Department fails to meet the performance measures delineated in the IGA.

**C.** The Department shall prepare, submit, and implement an effective corrective action plan for the Administration's finding under R9-22-906 when an office does not meet a level of compliance.

**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-908 renumbered and amended as Section R9-22-907, former Section R9-22-905 renumbered without change as Section R9-22-908 effective October 1, 1986 (Supp. 86-5). Former R9-22-908 repealed effective May 30, 1989 (Supp. 89-2). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-909. Annual Assessment Period Report**

The Administration shall issue an Annual Assessment Period Report. This report shall:

1. Serve as notification to the Department of the annual error rate determined for the Random Sample, Targeted Sample and Negative Case Action Sample,
2. Compare the error rate with the tolerance level for each sample, and
3. Serve as notification to the Department of a disallowed error rate and applicable financial sanction under A.R.S. § 36-2903.01.

**Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

## ARTICLE 10. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES

**R9-22-1001. Definitions**

In addition to the definitions in A.R.S. § 36-2901 and 9 A.A.C 22, Article 1, the following definitions apply to this Article:

"Cost avoid" means to deny a claim and return the claim to the provider for a determination of the amount of first- or third-party liability.

"First-party liability" means the obligation of any insurance or other coverage obtained directly or indirectly by a member that provides benefits directly to the member to pay all or part of the expenses for medical services incurred by AHCCCS or a member.

"Third-party" means a person, entity, or program that is, or may be, liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member.

"Third-party liability" means the obligation of a person, entity, or program by agreement, circumstance, or otherwise, to pay all or part of the medical expenses incurred by an applicant or member.

**Historical Note**

Former Section R9-22-712 renumbered and amended as Section R9-22-1001 effective October 1, 1985 (Supp. 85-5). Amended subsections (E) through (H) effective October 1, 1986 (Supp. 86-5). Amended subsections (B), (C), (E), and (F) effective December 22, 1987 (Supp. 87-4). Section repealed; new Section adopted effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

**R9-22-1002. General Provisions**

AHCCCS is the payor of last resort unless specifically prohibited by applicable state or federal law.

**Historical Note**

Section R9-22-529 adopted effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5). Amended subsections (C) and (D) effective October 1, 1986 (Supp. 86-5). Amended effective December 22, 1987 (Supp. 87-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed; new Section adopted effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

**R9-22-1003. Cost Avoidance**

**A.** AHCCCS shall cost avoid a claim if AHCCCS establishes the probable existence of first- or third-party liability or has information that establishes that first- or third-party liability exists.

**B.** When the amount of first- or third-party liability is determined, AHCCCS shall pay no more than the difference between the Capped Fee-For-Service Schedule amount and the amount of the first- or third-party liability.

**C.** The requirement to cost avoid applies to all AHCCCS-covered services under Article 2 of this Chapter, unless otherwise specified in this Section. The following parties shall take reasonable measures to identify potentially legally liable first- or third-party sources:

1. AHCCCS,
2. A provider,
3. A noncontracting provider, and
4. A member.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

**R9-22-1004. Member Participation**
A member shall cooperate in identifying potentially legally liable first- or third-parties and timely assist AHCCCS and a contractor, provider, or noncontracting provider in pursuing any first- or third-party who may be liable to pay for covered services.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

**R9-22-1005. Collections**
**A.** Parties that notify AHCCCS. A provider or noncontracting provider shall cooperate with AHCCCS by identifying all potential sources of first- or third-party liability and notify AHCCCS of these sources.
**B.** Parties that pursue collection or reimbursement. AHCCCS, a provider, or noncontracting provider shall pursue collection or reimbursement from all potential sources of first- or third-party liability.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

**R9-22-1006. AHCCCS Monitoring Responsibilities**
AHCCCS shall monitor first- or third-party liability payments to a provider or noncontracting provider, which include but are not limited to payments by or for:
1. Private health insurance;
2. Employment-related disability and health insurance;
3. Long-term care insurance;
4. Other federal programs not excluded by statute from recovery;
5. Court ordered or non-court ordered medical support from an absent parent;
6. State worker's compensation;
7. Automobile insurance, including underinsured and uninsured motorists insurance;
8. Court judgment or settlement from a liability insurer including settlement proceeds placed in a trust;
9. First-party probate estate recovery;
10. Adoption-related payment; or
11. A tortfeasor.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

**R9-22-1007. Notification for Perfection, Recording, and Assignment of AHCCCS Liens**
**A.** County requirements. The member's county of residence shall notify AHCCCS under R9-22-1008 within 30 days after providing hospital or medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a first- or third-party to enable AHCCCS to preserve lien rights under A.R.S. §§ 36-2915 and 36-2916.
**B.** Hospital requirements. A hospital providing medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a first- or third-party shall within 30 days after a member's discharge:
1. Notify AHCCCS via facsimile or mail under R9-22-1008, or
2. Mail AHCCCS a copy of the lien the hospital proposes to record or has recorded under A.R.S. § 33-932.
**C.** Provider and noncontracting provider requirements. A provider or noncontracting provider, other than a hospital, rendering medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a first- or third-party shall notify AHCCCS under R9-22-1008 within 30 days after providing the service.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

**R9-22-1008. Notification Information for Liens**
**A.** Except as provided in subsection (B), a county, hospital, provider, and noncontracting provider identified in R9-22-1007 shall provide the following information to AHCCCS in writing:
1. Name of the provider or noncontracting provider;
2. Address of the provider or noncontracting provider;
3. Name of member;
4. Member's Social Security Number or AHCCCS identification number;
5. Address of member;
6. Date of member's admission;
7. Amount estimated to be due for care of member;
8. Date of discharge, if member has been discharged;
9. Name of county in which injuries were sustained; and
10 Name and address of all persons, firms, and corporations and their insurance carriers claimed by the member or legal representative to be liable for damages.
**B.** If the date of discharge is not known at the time the information in subsection (A) is provided, a party identified in subsection (A) shall notify AHCCCS of the date of discharge within 30 days after the member has been discharged.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

**R9-22-1009. Notification of Health Insurance Information**
A provider or noncontracting provider shall notify AHCCCS, in writing, of the following health insurance information within 10 days of receipt of the health insurance information:
1. Name of member,
2. Member's Social Security Number or AHCCCS identification number,
3. Insurance carrier name,
4. Insurance carrier address,
5. Policy number or insurance holder's Social Security Number,
6. Policy begin and end dates, and
7. Insurance holder's name.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

## ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS

**R9-22-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims**
**A.** Circumstances for imposing a penalty and assessment. The Director or designee shall impose a penalty and assessment under the circumstances described in A.R.S. § 36-2918. For the purposes of this Article, the term "reason to know" means that a person, with respect to information, acts in deliberate ignorance of the truth or falsity of the information or with reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.
**B.** Violation of agreement. The Director's or designee's determination of whether a person knew or had reason to know that each claim or request for payment was claimed in violation of

an agreement with Arizona, the Administration, or a contractor may be based on the terms of the agreement.

**Historical Note**
Adopted effective October 1, 1986 (Supp. 86-5). Amended subsection A. effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective June 9, 1998 (Supp. 98-2).

**R9-22-1102. Determinations Regarding the Amount of the Penalty and Assessment**

**A.** Factors for determining a penalty and assessment. The Director or designee shall take into account the following factors in determining the amount of a penalty and assessment:
1. The nature of each claim or request for payment and the circumstances under which it is presented or caused to be presented,
2. The degree of culpability of a person who presents or causes to present each claim or request for payment,
3. The history of prior offenses of a person who presents or causes to present each claim or request for payment,
4. The financial condition of a person who presents or causes to present each claim or request for payment,
5. The effect on patient care resulting from the failure to provide medically necessary care by a person who presents or causes to present each claim or request for payment, and
6. Other matters as justice may require.

**B.** Types of claim circumstances. In determining the amount of a penalty and assessment, the Director or designee shall consider both mitigating circumstances and aggravating circumstances surrounding the presentation or cause for presentation of each claim or request for payment.

**C.** Mitigating circumstance guidelines. The Director or designee shall consider the following mitigating circumstance guidelines when determining the amount of a penalty and assessment:
1. Nature and circumstances of each claim or request for payment. The nature and circumstances of each claim or request for payment and the circumstances under which it is presented or is caused to be presented are a mitigating circumstance if:
   a. All the items and services subject to a penalty and assessment are of the same type,
   b. All the items and services subject to a penalty and assessment occurred within a short period of time,
   c. There are few items and services, and
   d. The total amount claimed for the items and services is less than $1,000;
2. Degree of culpability. The degree of culpability of a person who presents or causes to present a claim or request for payment is a mitigating circumstance if:
   a. Each item or service is the result of an unintentional and unrecognized error in the process the person followed in presenting or in causing to present the item or service,
   b. Corrective steps were taken promptly after the error was discovered, and
   c. A fraud and abuse control plan was adopted and operating effectively at the time each claim or request for payment was presented or caused to be presented;
3. Financial condition. The financial condition of a person who presents or causes to present a claim or request for payment is a mitigating circumstance if the imposition of a penalty and assessment without reduction will jeopardize the ability of the person to continue as a health care provider. The resources available to the person may be considered when determining the amount of the penalty and assessment; or
4. Other matters as justice may require. Other circumstances of a mitigating nature will be taken into account if, in the interest of justice, the circumstances require a reduction of the penalty and assessment.

**D.** Aggravating circumstance guidelines. The Director or designee shall consider the following aggravating circumstance guidelines when determining the amount of a penalty and assessment:
1. Nature and circumstances of each claim or request for payment. The nature and circumstances of each claim or request for payment and the circumstances under which it is presented or caused to be presented are an aggravating circumstance if:
   a. The items and services subject to a penalty and assessment are of several types,
   b. The items and services subject to a penalty and assessment occurred over a lengthy period of time,
   c. There are many items or services (or the nature and circumstances indicate a pattern of claims for the items or services), or
   d. The total amount claimed for the items and services is $1,000 or greater;
2. Degree of culpability. The degree of culpability of a person who presents or causes to present each claim or request for payment is an aggravating circumstance if:
   a. The person knew that each item or service was not provided as claimed,
   b. The person knew that no payment could be made because the person had been excluded from System reimbursement, or
   c. Payment would violate the terms of an agreement between the person and Arizona, the Administration, or a contractor;
3. Prior offenses. The prior offenses of a person who presents or causes to present each claim or request for payment is an aggravating circumstance if, at any time before the presentation of any claim or request for payment subject to a penalty and assessment under this Article, the person was held liable for a criminal, civil, or administrative sanction in connection with:
   a. A Medicaid program,
   b. A Medicare program, or
   c. Any other public or private program of reimbursement for medical services;
4. Effect on patient care. The seriousness of an adverse effect that resulted, or could have resulted, from the failure of a person who presents or causes to present a claim or request for payment to provide medically necessary care is an aggravating circumstance; or
5. Other matters as justice may require. Other circumstances of a aggravating nature will be taken into account if, in the interest of justice, the circumstances require an increase of the penalty and assessment.

**E**. Amount of Penalty and Assessment. The aggregate amount of a penalty and assessment shall never be less than double the approximate amount of damages sustained by Arizona, the Administration, or contractor, unless there are extraordinary mitigating circumstances.

**F.** Compromise. The Director or designee may compromise a penalty and assessment using the guidelines in subsections (C) and (D).

**Historical Note**
Adopted effective October 1, 1986 (Supp. 86-5).
Amended effective December 13, 1993 (Supp. 93-4).
Amended effective June 9, 1998 (Supp. 98-2).

**R9-22-1103. Notice of Proposed Determination and Rights of Parties**

**A.** Administration's Responsibilities. If the Director or designee proposes to impose a penalty and assessment, the Director or designee shall deliver or send by certified mail, return receipt requested, to a person, written notice of intent to impose a penalty and assessment. The notice shall include:
1. Reference to the statutory basis for the penalty and assessment,
2. A description of each claim or request for payment for which the penalty and assessment are proposed,
3. The reason why each claim or request for payment subjects the person to a penalty and assessment, and
4. The amount of the proposed penalty and assessment.

**B.** Individual's Responsibilities. A person may submit within 35 days from the date of the notice of intent to impose a penalty and assessment:
1. A written statement accepting imposition of the penalty and assessment;
2. A written request for a compromise of the penalty and assessment stating any reasons that the person contends should result in a reduction or modification of the penalty and assessment. If a request is submitted, the time period for filing an appeal and request for hearing according to subsection (C) shall be tolled until the Director's or designee's decision on the request for compromise; or
3. A grievance in accordance with the provider grievance provision in Article 8 of this Chapter.

**C.** The Director or designee may impose a proposed penalty and assessment or any less severe penalty and assessment if a person does not request a hearing within the time prescribed by subsections (B)(2) or (B)(3). A person has no right to appeal a penalty and assessment if the person has not timely requested a hearing.

**Historical Note**
Adopted effective October 1, 1986 (Supp. 86-5).
Amended effective December 13, 1993 (Supp. 93-4).
Amended effective June 9, 1998 (Supp. 98-2).

**R9-22-1104. Issues and Burden of Proof**

**A.** Preponderance of Evidence. In any hearing conducted according to this Article, the Director or designee shall prove by a preponderance of the evidence that a person who requested a hearing presented or caused to be presented each claim or request for payment in violation of R9-22-1101. A person who requests a hearing shall bear the burden of producing and proving by a preponderance of the evidence any circumstance that would justify reducing the amount of the penalty and assessment.

**B.** Statistical sampling.
1. The Director or designee may introduce the results of a statistical sampling study as evidence of the number and amount of claims or requests for payment that were presented or caused to be presented by the person in meeting the burden of proof described in subsection (A). A statistical sampling study shall constitute prima facie evidence of the number and amount of claims or requests for payment, if based upon an appropriate sampling and computed by valid statistical methods.
2. The burden of proof shall shift to the person to produce evidence reasonably calculated to rebut the findings of the statistical sampling study once the Director or designee has made a prima facie case as described in subsection (A). The Director or designee will be given the opportunity to rebut this evidence.

**Historical Note**
Adopted effective October 1, 1986 (Supp. 86-5).
Amended effective June 9, 1998 (Supp. 98-2).

## ARTICLE 12. BEHAVIORAL HEALTH SERVICES

**R9-22-1201. General Requirements**

General requirements. The following general requirements apply to behavioral health services provided under this Article, subject to all exclusions and limitations.
1. Administration. The program shall be administered as specified in A.R.S. § 36-2903.
2. Provision of services. Behavioral health services shall be provided as specified in A.R.S. § 36-2907 and this Chapter.
3. Definitions. The following definitions apply to this Article:
   a. "Case management" means supportive services and activities that enhance treatment, compliance, and effectiveness of treatment.
   b. "Physician assistant" specified in A.R.S. § 32-2501. In addition, a physician assistant providing a behavioral health service shall be supervised by an AHCCCS-registered psychiatrist.
   c. "Respite" means a period of care and supervision of a member to provide an interval of rest or relief to a family member or other person caring for the member. Respite provides activities and services to meet the social, emotional, and physical needs of the member during the respite period.
   d. "Substance abuse" means the chronic, habitual, or compulsive use of any chemical matter which, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not a considered substance abuse for adults who are 21 years of age or older.
   e. "TRBHA" means a Tribal Regional Behavioral Health Authority.
   f. "Therapeutic foster care services" means services provided in a licensed foster home by qualified and trained foster parents who implement the in-home portion of a member's behavioral health treatment plan. The implementation of the plan allows the member to remain in the community versus requiring more intensive level of services.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4).
Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1202. ADHS and Contractor Responsibilities**

**A.** ADHS responsibilities. Behavioral health services shall be provided by a RBHA through a contract with ADHS. ADHS shall:
1. Contract with a RBHA for the provision of behavioral health services in R9-22-1205 for all Title XIX members under A.R.S. § 36-2907. ADHS shall ensure that a RBHA provides behavioral health services to members directly, or through subcontracts, with qualified service providers who meet the qualifications specified in R9-22-1206. If behavioral health services are unavailable within a RBHA's service area, ADHS shall ensure that a RBHA provides behavioral health services to a Title XIX member outside the RBHA's service area.
2. Ensure that a member's behavioral health service is provided in collaboration with a member's primary care provider.
3. Coordinate the transition of care and medical records, under A.R.S. §§ 36-2903, 36-509, A.A.C. R9-22-512, and in contract, when a member transitions from:
   a. A behavioral health provider to another behavioral health provider,
   b. A RBHA to another RBHA,
   c. A RBHA to a health plan contractor,
   d. A contractor to an a RBHA, or
   e. A contractor to another health plan contractor.

**B.** ADHS may contract with a TRBHA for the provision of behavioral health services for Native American members. In the absence of a contract with ADHS, Native American members may:
1. Receive behavioral health services from an IHS facility or a TRBHA, or
2. Be referred off-reservation to an a RBHA for covered behavioral health services.

**C.** Contractor responsibilities. A health contractor shall:
1. Refer a member to an a RBHA under the contract terms;
2. Provide EPSDT developmental and behavioral health screening specified in R9-22-213;
3. Provide inpatient emergency behavioral health services specified in R9-22-1205 for a member not yet enrolled with a RBHA;
4. Provide psychotropic medication services for a member, in consultation with the member's RBHA as needed, for behavioral health conditions specified in contract and within the primary care provider's scope of practice; and
5. Coordinate a member's transition of care and medical records under R9-22-1202.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct typographical errors, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4).

**R9-22-1203. Eligibility for Covered Services**

**A.** Title XIX members. A member determined eligible under A.R.S. § 36-2901(6)(a), shall receive medically necessary covered services under R9-22-1205.

**B.** FES members. A person who would be eligible under A.R.S. § 36-2901(6)(a)(i), A.R.S. § 36-2901(6)(a)(ii), and A.R.S. § 36-2901(6)(a)(iii) except for the failure to meet the U.S. citizenship or qualified alien status requirements under A.R.S. § 36-2903.03(A) and A.R.S. § 36-2903.03(B) or A.R.S. § 36-2903.03(C) is eligible for emergency services only.

**C.** Ineligibility. A person is not eligible for behavioral health services if the person is:
1. An inmate of a public institution as defined in 42 CFR 435.1009,
2. A resident of an institution for the treatment of tuberculosis, or
3. Age 21 through 64 who is a resident of an IMD, and exceeds the limits under R9-22-1205.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1204. General Service Requirements**

**A.** Services. Behavioral health services include both mental health and substance abuse services.

**B.** Medical necessity. A service shall be medically necessary as under R9-22-201.

**C.** Prior authorization. A service shall be provided by contractors, subcontractors, and providers consistent with the prior authorization requirements established by the Director and under R9-22-210 and R9-22-1205.

**D.** EPSDT. For Title XIX members under age 21, EPSDT services shall include all medically necessary Title XIX-covered services that are necessary to provide behavioral health services to a member.

**E.** Experimental services. The Director shall determine if a service is experimental, or whether a service is provided primarily for the purpose of research. Those services shall not be covered.

**F.** Gratuities. A service or an item, if furnished gratuitously to a member, is not covered and payment shall be denied to a provider.

**G.** Service area. Behavioral health services rendered to a member shall be provided within the RBHA's service area except when:
1. A contractor's primary care provider refers a member to another area for medical specialty care,
2. A member's medically necessary covered service is not available within the service area, or
3. A net savings in behavioral health service delivery costs can be documented by the RBHA for a member. Undue travel time or hardship shall be considered for a member or a member's family.

**H.** Travel. If a member travels or temporarily resides out of a behavioral health service area, covered services are restricted to emergency behavioral health care, unless otherwise authorized by the member's RBHA.

**I.** Non-covered services. If a member requests a behavioral health service that is not covered by AHCCCS or is not authorized by a RBHA, the behavioral health service may be provided by an AHCCCS-registered behavioral health service provider under the following conditions:
1. The requested service and the itemized cost of each service is documented and provided to the member or member's guardian; and
2. The member or the member's guardian signs a statement acknowledging:
   a. Services have been explained to the member or member's guardian, and
   b. The member or member's guardian accepts responsibility for payment.

**J.** Referral. If a member is referred out of a RBHA service area to receive an authorized medically necessary behavioral health service or a medically necessary covered service the services shall be provided by the contractor or RBHA.

**K.** Restrictions and limitations.
1. The restrictions, limitations, and exclusions in this Article shall not apply to a contractor or a RBHA when electing to provide a noncovered service.
2. Room and board is not a covered service unless provided in an inpatient, sub-acute, or residential facility under R9-22-1205.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective January 1, 1996; filed with the Secretary of State December 22, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1205. Scope and Coverage of Behavioral Health Services**

**A.** Inpatient behavioral health services. The following inpatient services shall be covered subject to the limitations and exclusions in this Article.
1. Inpatient behavioral health services provided in a Medicare (Title XVIII) certified hospital include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment. The behavioral health service shall be provided under the direction of a physician in:
   a. A general acute care hospital, or
   b. An inpatient psychiatric hospital.
2. Inpatient service limitations:
   a. Inpatient services, other than emergency services specified in this Section, shall be prior authorized.
   b. Inpatient services and room and board shall be reimbursed on a per diem basis and shall be inclusive of all services, except the following may bill independently for services:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant,
      iv. A psychologist,
      v. A certified independent social worker,
      vi. A certified marriage and family therapist,
      vii. A certified professional counselor, or
      viii. A behavioral health medical practitioner.
   c. A member age 21 through 64 is eligible for behavioral health services provided in a hospital listed in Section (A)(1)(b) that meets the criteria for an IMD up to 30 days per admission and no more than 60 days per contract year as allowed under the Administration's Section 1115 Waiver with CMS.

**B.** Level I Residential Treatment Center Services. The following Residential Treatment Center services shall be covered subject to the limitations and exclusions under this Article.
1. Level I Residential Treatment Center services shall be provided under the direction of a physician in a Level I Residential Treatment Center accredited by an AHCCCS approved accrediting body as specified in contract.
2. Residential Treatment Center services include room and board and treatment services for mental health and substance abuse conditions.
3. Residential Treatment Center service limitations:
   a. Services shall be prior authorized, except for emergency services as specified in this Section.
   b. Services shall be reimbursed on a per diem basis and shall be inclusive of all services, except the following may bill independently for services:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant,
      iv. A psychologist,
      v. A certified independent social worker,
      vi. A certified marriage and family therapist,
      vii. A certified professional counselor, or
      viii. A behavioral health medical practitioner.
4. The following services may be billed independently if prescribed by a provider specified in this Section:
   a. Laboratory,
   b. Radiology, and
   c. Psychotropic medication.

**C.** Level I Sub-acute Facility Services. The following sub-acute facility services shall be covered subject to the limitations and exclusions under this Article.
1. Level I sub-acute facility services shall be provided under the direction of a physician in a Level I sub-acute facility accredited by an AHCCCS approved accrediting body as specified in contract.
2. Level I sub-acute services include room and board and treatment services for mental health and substance abuse conditions.
3. Services shall be reimbursed on a per diem basis and shall be inclusive of all services, except the following may bill independently for services:
   a. A psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A physician assistant,
   d. A psychologist,
   e. A certified independent social worker,
   f. A certified marriage and family therapist,
   g. A certified professional counselor, or
   h. A behavioral health medical practitioner.

4. The following services may be billed independently if prescribed by a provider specified in this Section:
   a. Laboratory,
   b. Radiology, and
   c. Psychotropic medication.
5. A member age 21 through 64 is eligible for behavioral health services provided in a subacute facility that meets the criteria for an IMD for up to 30 days per admission and no more than 60 days per contract year as allowed under the Administrations's Section 1115 Waiver with CMS.

**D.** ADHS licensed Level II Behavioral Health Residential Services. The following Level II Behavioral Health Residential services shall be covered subject to the limitations and exclusions in this Article.
1. Level II Behavioral Health services shall be provided by a licensed Level II agency.
2. Services shall be inclusive of all covered services except room and board.
3. The following may bill independently for services:
   a. A psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A physician assistant,
   d. A psychologist,
   e. A certified independent social worker,
   f. A certified marriage and family therapist,
   g. A certified professional counselor, or
   h. A behavioral health medical practitioner.

**E.** ADHS licensed Level III Behavioral Health Residential Services. The following Level III Behavioral Health Residential services shall be covered subject to the limitations and exclusions under this Article.
1. Level III Behavioral Health services shall be provided by a licensed Level III agency.
2. Services shall be inclusive of all covered services except room and board.
3. The following may bill independently for services:
   a. A psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A physician assistant,
   d. A psychologist,
   e. A certified independent social worker,
   f. A certified marriage and family therapist,
   g. A certified professional counselor, or
   h. A behavioral health medical practitioner.

**F.** Partial care. The following partial care services shall be covered subject to the limitations and exclusions in this Article.
1. Partial care shall be provided by an agency qualified to provide a regularly scheduled day program of individual member, group or family activities that are designed to improve the ability of the member to function in the community.
2. Partial care service exclusions. School attendance and educational hours shall not be included as a partial care service and shall not be billed concurrently with these services.

**G.** Outpatient services. The following outpatient services shall be covered subject to the limitations and exclusions in this Article.
1. Outpatient services shall include the following:
   a. Screening provided by a behavioral health professional or a behavioral health technician;
   b. Initial behavioral health evaluation provided by a behavioral health professional;
   c. Ongoing behavioral health evaluation by a behavioral health professional or a behavioral health technician;
   d. Counseling including individual therapy, group, and family therapy provided by a behavioral health professional or a behavioral health technician;
   e. Behavior management services provided by qualified individuals or agencies as specified in contract; and
   f. Psychosocial rehabilitation services provided by qualified individuals or agencies as specified in contract.
2. Outpatient service limitations:
   a. The following practitioners may bill independently:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant as defined in this Article,
      iv. A psychologist,
      v. A certified independent social worker,
      vi. A certified professional counselor,
      vii. A certified marriage and family therapist,
      viii. A behavioral health medical practitioner,
      ix. A therapeutic foster parent, and
      x. Other AHCCCS registered providers as specified in contract.
   b. Other behavioral health professionals and qualified persons not specified in subsection (G)(2)(a) shall be employed by, or contracted with, an AHCCCS-registered behavioral health agency.

**H.** Behavioral health emergency services. The following emergency services are covered subject to the limitations and exclusions under this Article.
1. A RBHA shall ensure that behavioral health emergency services are provided by the qualified personnel under R9-22-1206. The emergency services shall be available 24 hours-per-day, seven days-per-week in the RBHA's service area in emergency situations when a member is a danger to self or others or is otherwise determined in need of immediate unscheduled behavioral health services. Behavioral health emergency services may be provided on either an inpatient or outpatient basis.
2. A contractor shall provide behavioral health emergency services under R9-22-210(D) on an inpatient basis not to exceed three days per emergency episode and 12 days per contract year, for a member not yet enrolled with a RBHA.
3. An inpatient emergency service provider shall verify the eligibility and enrollment of a member through the Administration to determine the need for notification to a contractor or a RBHA and to determine the party responsible for payment of services under Article 7.
4. Behavioral health emergency service limitations:
   a. An emergency behavioral health service does not require prior authorization. The provider shall, however, comply with the notification requirements under R9-22-210.
   b. A behavioral health service for an unrelated condition, that requires evaluation, diagnosis, and treatment shall be prior authorized by a RBHA.

**I.** Other behavioral health services. Other behavioral health services include:
1. Case management as defined in R9-22-1201;
2. Laboratory and radiology services for behavioral health diagnosis and medication management;
3. Psychotropic medication and related medication;

4. Medication monitoring, administration, and adjustment for psychotropic medication and related medications;
5. Respite care;
6. Therapeutic foster care services provided in a family foster home defined in 6 A.A.C. 5, Article 58 or adult therapeutic foster home defined in 9 A.A.C. 20 Articles 1 and 15;
7. Personal assistance; and
8. Other support services to maintain or increase the member's self-sufficiency and ability to live outside an institution.

**J.** Transportation services.
1. Emergency transportation shall be covered for a behavioral health emergency under R9-22-211. Emergency transportation is limited to behavioral health emergencies.
2. Non-emergency transportation shall be covered to and from covered behavioral health service providers.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4).
Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1206. General Provisions and Standards for Service Providers**

**A.** Qualified service provider. A qualified behavioral health service provider shall:
1. Be a non-contracting provider or employed by, or contracted in writing with, a RBHA or a contractor to provide behavioral health services to a member;
2. Have all applicable state licenses or certifications, or comply with alternative requirements established by the Administration;
3. Register with the Administration as a service provider; and
4. Comply with all requirements under Article 5 and this Article.

**B.** Quality and utilization management.
1. Service providers shall cooperate with the quality and utilization management programs of a RBHA, a contractor, ADHS, and the Administration under R9-22-522 and contract.
2. Service providers shall comply with applicable procedures under 42 CFR 456.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4).
Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1207. Standards for Payments**

**A.** Payment to ADHS. ADHS shall receive a monthly capitation payment, based on the number of acute care members at the beginning of each month. ADHS administrative costs shall be incorporated into the capitation payment.

**B.** Claims submissions.
1. ADHS shall require all contracted service providers to submit clean claims no later than the time-frame specified in the ADHS contract with the Administration.
2. A claim for emergency services for a member not yet enrolled with an RBHA shall be submitted to a health plan by a provider and shall comply with the time-frames and other applicable payment procedures in Article 7.

**C.** Prior authorization. Payment to a provider for services or items requiring prior authorization may be denied if prior authorization is not obtained from the Administration, an RBHA, or a health plan as specified in R9-22-705.

**Historical Note**
Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4).

**R9-22-1208. Grievance and Request for Hearing Process**

**A**. Processing a grievance. A grievance for an adverse action for a behavioral health service shall be processed as specified in 9 A.A.C. 22, Articles 8 and 13 and under A.R.S. §§ 36-2903.01, 36-3413, and 41-1092 et seq. The grievance and request for hearing process is illustrated in 9 A.A.C. 22, Article 8, Exhibit A.

**B**. Member request for hearing. A member's request for hearing for a grievance under this Article shall be conducted as specified in 9 A.A.C. 22, Article 8.

**Historical Note**
New Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4).
Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3).

**ARTICLE 13. REPEALED**

*Article 13, consisting of Sections R9-22-1301 through R9-22-1309, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 13 is now in 9 A.A.C. 34 (Supp. 04-1).*

**R9-22-1301. Repealed**

**Historical Note**
Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-1302. Repealed**

**Historical Note**
Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-1303. Repealed**

**Historical Note**
Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-1304. Repealed**

**Historical Note**
Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-1305. Repealed**

**Historical Note**
Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-1306. Repealed**

**Historical Note**
Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-1307. Repealed**

**Historical Note**
Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-1308. Repealed**

**Historical Note**
Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-1309. Repealed**

**Historical Note**
Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

## ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR FAMILIES AND INDIVIDUALS

**R9-22-1401. General Information**
This Article contains eligibility criteria to determine if a family or individual is eligible for AHCCCS medical coverage.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1402. Ineligible Person**
A person is not eligible for AHCCCS medical coverage if the person is:

1. An inmate of a public institution if federal financial participation (FFP) is not available, or
2. Age 21 through age 64 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except when allowed under the Administration's Section 1115 IMD waiver with CMS.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1403. Agency Responsible for Determining Eligibility**
The Department shall determine eligibility under the provisions of this Article. The Department shall not discriminate against an eligible person or member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental disability in accordance with Title VI of the U.S. Civil Rights Act of 1964, 42 U.S.C. 2000d, and rules and regulations promulgated according to, or as otherwise provided by law.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1404. Confidentiality**
The Administration and Department shall maintain the confidentiality of an applicant's or member's records and shall not disclose an applicant's or member's financial, medical, or other confidential information except as allowed under R9-22-512 and 6 A.A.C.12, Article 1.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1405. Application Process**

**A.** Right to apply. A person identified in subsection (B) may apply for AHCCCS medical coverage by submitting a signed Department or Administration approved application to the Administration, an FAA office or an outstation location under 42 CFR 435.904 listed below:

1. A BHS site as provided in Laws 1991, Ch. 213, § 21;
2. A CRS site as provided in Laws 1991, Ch. 213, § 21;
3. A Baby Arizona approved provider's office, if the applicant is a pregnant woman;
4. A FQHC or disproportionate share hospital under 42 U.S.C. 1396r-4, as required by 42 CFR 435.904, or;
5. Any other site, including a hospital, approved by the Department or the Administration.

**B.** Who may apply for a person. Any of the following may submit an application for an applicant:
1. The applicant's legal representative;
2. The applicant;
3. The applicant's spouse;
4. The applicant's parent;
5. The applicant's authorized representative, designated by the applicant either verbally in the presence of an employee of the Administration or its designee, or in writing;
6. An adult who lives with the applicant;
7. The applicant's adult child; or
8. Another party if the applicant is an adult who is incapacitated, a child less than 18 years old, or a child who is age 18 and a student. The Administration or its designee shall require incapacity to be verified by written documentation signed by a licensed physician or by one of the following:
   a. A physician assistant;
   b. A nurse practitioner; or
   c. A registered nurse, under the direction of a licensed physician.

**C.** Written application. To initiate the application process, a person listed in subsection (B) shall submit a written application under 42 CFR 435.907 to one of the sites listed in subsection (A).
1. A written application is one that contains the legible name and address, or location where the applicant can be reached, of each person requesting AHCCCS medical coverage and the signature of the person under subsection (B) who is submitting the application. The Administration shall require that a third party witness the signing and co-sign the application if the individual signing the application signs with a mark.
2. The Administration or its designee shall accept an application for a person who is incapacitated and whose name and address are not known.

**D.** Date of application.
The date of application is the date a written application is received at a location listed in subsection (A).

**E.** Complete application form.
1. An applicant shall provide all information requested on the application form.
2. The Administration or its designee shall not approve an application unless the applicant's legal representative, if one exists, signs the declarations on the application relating to the applicant's eligibility, under penalty of perjury. A legal representative is a custodial parent of a child under 18, a guardian, or a conservator.
3. If there is no legal representative, or the legal representative is incapacitated, one of the following shall sign the declarations on the application relating to the applicant's eligibility, under penalty of perjury:
   a. The applicant, if age 18 or older;
   b. The applicant, if less than 18 years old and married or not living with a parent;
   c. The applicant's spouse if not separated;
   d. An adult who lives with a child who is less than 18 years old or age 18 if a student;
   e. Unmarried partners if living together with a child in common, if the child is an applicant or a member; or
   f. Another party, if the applicant is incapacitated and no one listed in subsections (E)(3)(a) through (e) is available to sign the application on the applicant's behalf. The Administration shall require incapacity to be verified by written documentation signed by a licensed physician or by one of the following:
      i. A physician assistant,
      ii. A nurse practitioner, or
      iii. A registered nurse under the direction of a licensed physician.
4. Unrelated adults not applying for a child in common shall each sign the application if using the same application form.
5. A person in listed in subsection (E)(2) or (E)(3)(a) through (e) may authorize, verbally in the presence of an employee of the Administration or its designee or in writing, someone else to represent the applicant in the application process. The authorized representative may sign the declarations on the application relating to the applicant's eligibility, under penalty of perjury.
6. The application shall be witnessed and signed by a third party if the individual signing the application signs with a mark.

**F.** Assistance with application. The Administration or its designee shall allow a person of the applicant's choice to accompany, assist, and represent the applicant in the application process.

**G.** Applicants who die. If an applicant dies while an application is pending, the Administration or its designee shall complete an eligibility determination for all applicants listed on the application, including the deceased applicant.

**H.** Deceased applicants. The Administration or designee shall complete an eligibility determination on an application filed on behalf of a deceased applicant, if the application is filed in the month of the applicant's death.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4).

**R9-22-1406. Applicant and Member Responsibility**

**A.** An applicant and member shall authorize the Department to obtain verification.

**B.** As a condition of eligibility, an applicant and member shall:
1. Give the Department complete and truthful information. The Department may deny an application or discontinue eligibility if:
   a. The applicant or member fails to provide information necessary for initial or continuing eligibility,
   b. The applicant or member fails to provide the Department with written authorization to permit the Department to obtain necessary verification,
   c. The applicant or member fails to provide verification under R9-22-1410 after the Department had made an effort to obtain the necessary verification but has not obtained the necessary information, or
   d. The applicant or member does not assist the Department in resolving incomplete, inconsistent, or unclear information that is necessary for initial or continuing eligibility.
2. Comply with the DCSE under 42 CFR 433.148 in establishing paternity and enforcing medical support obligations when requested. The Department shall not deny AHCCCS eligibility to any applicant who would otherwise be eligible and who is a minor child and whose parent or legal representative does not cooperate with the

medical support requirements under subsection (E) or first-and third-party liability under Article 10;
3. Provide information concerning third-party coverage for medical care.

**C.** The member shall:
1. Send to the Department any medical support payments received resulting from a medical support order while the member is eligible;
2. Cooperate with the Administration regarding any issues arising under the Medicaid Eligibility Quality Control Program under Article 9; and
3. Inform the Department of the following changes within 10 days from the date the applicant or member knows of a change:
   a. In address,
   b. In the household's composition,
   c. In income,
   d. In resources, when required for the Medical Expense Deduction (MED) program under R9-22-1430,
   e. In Arizona state residency,
   f. In citizenship or immigrant status,
   g. In first- or third-party liability which may contribute to the payment of all or a portion of the person's medical costs, or
   h. That may affect the person's eligibility including a change in a woman's pregnancy status.

**D.** As a condition of eligibility, an applicant or member shall apply for other benefits as required under 42 CFR 435.608.

**E.** As a condition of eligibility, an applicant or member shall cooperate with the Assignment of Rights and if the applicant or member receives first- or third-party care and services, the applicant or member shall:
1. Cooperate with the Department and the Administration in identifying and providing information to assist the state in pursuing any first- or third-party who may be liable to pay for medical care and services.
2. Except as provided in subsections (3) and (4), a parent, legal representative, or other legal responsible adult who applies for AHCCCS medical coverage on behalf of a child shall cooperate with the Department to establish paternity and obtain medical support or other payments as provided in A.R.S. § 46-292(C).
3. A pregnant woman under A.R.S. § 36-2901(6)(a)(ii) is not required to provide the Department with information regarding paternity or medical support from a father of a child born out of wedlock.
4. A parent, who is not requesting AHCCCS medical coverage, is not required to provide the Department with information regarding paternity or medical support from an absent parent.

**F.** At an initial application interview and at any review, the Department shall explain to the applicant or member the following requirements:
1. To comply with DCSE in establishing paternity and enforcing medical support except in circumstances when good cause under 42 CFR 433.147 exists for not cooperating,
2. To establish good cause for not complying with DCSE in establishing paternity and enforcing medical support,
3. To report a change listed in subsection (C) no later than 10 days from the date the applicant or member knows of the change;
4. To send to the Department any medical support received through a Title IV-D court order;
5. To cooperate with assignment of rights and securing payments received from any liable party for a member's medical care.

**G.** The applicant or member shall provide the following health insurance information, if applicable, at the initial interview and at any review:
1. Name of policyholder,
2. Policyholder's relationship to the applicant,
3. SSN of the policy holder,
4. Name and address of the insurance company, and
5. Policy number.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1407. Withdrawal of Application**

**A.** An applicant may withdraw an application at any time before the Department completes an eligibility determination by making an oral or written request for withdrawal and stating the reason for withdrawal.

**B.** If an applicant orally requests to withdraw the application, the Department shall document the:
1. Date of the request,
2. Name of the applicant for whom the withdrawal applies,
3. Reason for the withdrawal,

**C.** An applicant may withdraw an application in writing by:
1. Completing a Department approved voluntary withdrawal form; or
2. Submitting a written, signed, and dated request to withdraw the application.

**D.** The effective date of the withdrawal is the date of the application.

**E.** If an applicant requests to withdraw an application, the Department shall:
1. Deny the application, and
2. Notify the applicant of the denial following the notice requirements under R9-22-1411.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1408. Eligibility Interview or Home Visit**

**A.** Scheduling an interview or home visit.
1. Upon receipt of an application, the Department shall:
   a. Schedule an initial eligibility interview or home visit at the request of a homebound applicant or if the Department believes that a home visit may avoid an eligibility error, and
   b. Provide the applicant a written notice of the scheduled interview;
2. The Department shall not require a separate interview unless the application received does not include sufficient information to determine eligibility under this Article for an applicant whose application is received from:
   a. A Baby Arizona provider,
   b. A KidsCare office,
   c. A CRS office, or
   d. Another agency or entity approved by the Administration,

**B.** Attend the interview. As a condition of eligibility, the applicant or the applicant's representative shall attend the interview.

**C.** Department's requirement at interview. During the initial interview or review, a Department representative shall:
1. Offer to help the applicant or member to complete the application form and to obtain required verification;
2. Provide the applicant or member with information explaining:
   a. The eligibility and verification requirements of AHCCCS medical coverage;
   b. The requirement that the applicant or member obtain and provide a SSN to the Department;
   c. How the Department uses the SSN;
   d. The Department's practice of exchanging eligibility and income information through the SVES;
   e. The applicant and member's rights and responsibilities, including the right to appeal an adverse action;
   f. The assignment of rights under operation of law as provided in A.R.S. § 36-2903,
   g. That the Department will use information to complete data matches with potential liable parties;
   h. The eligibility review process;
   i. The program coverage and the types of services available under each program;
   j. The family planning services available through AHCCCS health plans if appropriate;
   k. The AHCCCS pre-enrollment process;
   l. Availability of continued AHCCCS medical coverage under R9-22-1420, and
   m. That the Department shall help the applicant or member obtain necessary verification if the applicant or member asks for help.
3. Review the penalties for perjury and fraud printed on the application;
4. Explain whose income is counted;
5. Review any verification information provided by the applicant or member and give a written list of additional verification items and time-frames that the applicant or member shall provide to the Department;
6. Explain the applicant and member's responsibilities under R9-22-1406; and
7. Review all reporting requirements and explain that the applicant or member may lose the earned income disregards defined in R9-22-1419, if the applicant or member fails to report changes timely; and
8. Explain the MED program under R9-22-1427 through R9-22-1432.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1409. Withdrawal from AHCCCS Medical Coverage**

**A.** A member may withdraw from AHCCCS medical coverage at any time by making an oral or written request for withdrawal to the Department. The member or the member's legal or authorized representative shall provide the Department with:
1. The reason for the withdrawal,
2. The date the request is effective, and
3. The name of the member for whom AHCCCS medical coverage is being withdrawn.

**B.** The Department shall discontinue eligibility for AHCCCS medical coverage for all family members if the request to withdraw does not identify a specific person.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1410. Verification of Eligibility Information**

**A.** The applicant or member has the primary responsibility to provide the Department with information necessary to verify eligibility and complete the determination of eligibility at the time of initial application, at a time when change in circumstances occurs which may affect eligibility, or at the eligibility review. With the exception of subsection (B), verification of information shall be obtained using the following types of documents in the following order:
1. First, documented verification which is written evidence originating from an agency, organization, or an individual qualified to have knowledge of the required information;
2. Second, collateral contact which is a verbal statement from an agency, organization, or individual qualified to have knowledge of the required information, or
3. Third, applicant's statement which shall only be used if:
   a. Documented,
   b. Collateral verification is not available, and
   c. The statement is not inconsistent or contracted with other information.

**B.** Documented verification is the only acceptable form of verification which can be accepted for:
1. SSN,
2. Alien status,
3. Relationship when questionable, and
4. Citizenship when questionable.

**C.** The Department shall provide an applicant or member no less than 10 days from the date of a written request for the information to provide required verification. The Department may deny the application or discontinue eligibility if an applicant or member does not provide the required information timely.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1411. Time-frames, Approval, or Denial of the Application**

**A.** Application processing time. The Department shall complete an eligibility determination under 42 CFR 435.911 within 45 days after the application date under R9-22-1405; unless:
1. The applicant is pregnant. The Department shall determine eligibility for a pregnant woman within 20 days after the application date unless additional information is required to determine eligibility, or
2. The applicant is in a hospital as an inpatient at the time of application. Within seven days of the Department's receipt of a signed application the Department shall:
   a. Complete an eligibility interview and ask all of the questions on the application, and
   b. Complete an eligibility determination if the Department does not need additional information or verification.

**B.** Approval. If the applicant meets all the eligibility requirements and conditions of eligibility of this Article, the Department shall approve the application and provide the applicant an approval notice. The approval notice shall contain:
1. The name of each approved applicant,
2. The effective date of eligibility defined in R9-22-1414 for each approved applicant,
3. The supporting reason and the legal citations if a member is approved for only emergency medical services, and
4. The applicant's or member's appeal rights.

**C.** Denial. If an applicant fails to meet the eligibility requirements or conditions of eligibility of this Article, the Department shall deny the application and provide the applicant a denial notice. The denial notice shall contain:
1. The name of each ineligible applicant;
2. The specific reason why the applicant is ineligible;
3. The income and the resource calculations compared to the income or resource standards when the reason for the denial is due to the applicant's income or resources exceeding the applicable standard;
4. The legal citations supporting the reason for the ineligibility;
5. The location where the applicant can review the legal citations,
6. The month of ineligibility; and
7. The applicant's right to appeal the decision and request a hearing.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1412. Review of Eligibility**
**A.** Except as provided in subsection (B), the Department shall complete a review of each member's continued eligibility for AHCCCS medical coverage at least once every:
1. Six months for a member determined eligible under R9-22-1420 and R9-22-1434;
2. Six months for a member determined eligible under R9-22-1421(3), except for a member under subsection (B)(4);
3. Twelve months for a member determined eligible under R9-22-1421(1) and (2), R9-22-1422, R9-22-1425, and R9-22-1426.

**B.** The Department shall complete a review of eligibility for a:
1. Pregnant woman determined eligible under R9-22-1421(1), following the termination of her pregnancy,
2. Non-pregnant member approved only for emergency medical services at least once in a six-month period,
3. Member approved for the MED program under R9-22-1427 through R9-22-1432 prior to the end of the six-month eligibility period,
4. Child under R9-22-1421(3) who has not attained 19 years of age and whose family income does not exceed 100 percent of the federal poverty guidelines, every 12 months,
5. Any time there is a change in a member's circumstance which may affect eligibility.

**C.** If a member continues to meet all eligibility requirements and conditions of eligibility, the Department shall authorize continued eligibility and notify the member of continued eligibility.

**D.** The Department shall discontinue eligibility and shall notify the member of the discontinuance under R9-22-1413 if the member:
1. Fails to comply with the review of eligibility,
2. Fails to comply with the requirements and conditions of eligibility under this Article without good cause under 42 CFR 433.148, or
3. Does not meet the eligibility requirements.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by exempt rulemaking at 10 A.A.R. 23, effective December 9, 2003 (Supp. 03-4).

**R9-22-1413. Notice of Discontinuance Action**
**A.** Notice requirement. If a member fails to meet an eligibility requirement or condition of eligibility, the Department shall provide the member an advance Notice of Action for an adverse action no later than 10 days before the effective date of the discontinuance.

**B.** The Department may mail an adverse Notice of Action no later than the effective date of the discontinuance if the Department:
1. Receives a request to withdraw under R9-22-1409,
2. Receives verification that the member is ineligible under R9-22-1402,
3. Has documented information confirming the death of a member,
4. Receives returned mail with no forwarding address from the post office and the member's whereabouts are unknown; or
5. Verifies that the member has been approved for Medicaid by another state.

**C.** The notice shall contain:
1. The name of each ineligible member;
2. The specific reason why the member is ineligible;
3. The income and the resource calculations compared to the income or resource standards when the reason for the discontinuance is due to the member's income or resources exceeding the applicable standard;
4. The legal citations supporting the reason for the ineligibility;
5. The location where the member can review the legal citations,
6. The date the discontinuance is effective, and
7. The member's appeal rights and right to continued medical coverage pending appeal.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1414. Effective Date of Eligibility**
Except for the MED program under R9-22-1427 through R9-22-1432 and eligibility for a newborn under R9-22-1422, the effective date of eligibility is the first day of the month that the applicant files an application if the applicant is eligible that month, or the first day of the first eligible month following the application month.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1415. Operation of Law**
A person determined eligible assigns rights to all types of medical benefits to which the person is entitled under operation of law under A.R.S. § 36-2903.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1416. Social Security Number**
As a condition of eligibility, an applicant shall furnish a SSN, under 42 CFR 435.910 and 435.920. A person who cannot legally obtain a SSN is not required to furnish a SSN. An applicant has until the

first review to provide a SSN as long as the applicant is cooperating with the Department to obtain a SSN. If an applicant cannot recall or has not been issued a SSN, the Department shall assist in obtaining or verifying the applicant's SSN under 42 CFR 435.910.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1417. State Residency**
As a condition of eligibility, an applicant or member shall be a resident of Arizona under 42 CFR 435.403.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1418. Citizenship and Immigrant Status**

**A.** As a condition of eligibility for full services under Article 2, an applicant or member shall be a citizen of the United States, or shall meet requirements for qualified alien under A.R.S. §§ 36-2903.03(A) and 36-2903.03(B), or A.R.S. § 36-2903.03(C).

**B.** An applicant is eligible for emergency medical services defined in R9-22-217 when the applicant is either a qualified alien or noncitizen:
1. Meets all other eligibility requirements, except those in subsection (A), and
2. Is eligible under A.R.S. § 36-2901(6)(a)(i), (ii), or (iii).

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1419. Income Eligibility Criteria**

**A.** Evaluation of income. In determining eligibility, the Department shall evaluate the following types of income received by a person identified in subsection (B):
1. Earned income, including in-kind income, before any deductions. For purposes of this Section, in-kind income means room, board, or provision for other needs in exchange for work performed. The provider of the in-kind income shall establish and verify the monetary value of the item provided. The provider may be, but is not limited to:
   a. A landlord who provides all or a portion of rent or utilities in exchange for services;
   b. A store owner who gives goods such as groceries, clothes, or furniture in exchange for services; or
   c. An individual who trades goods such as a car, tools, trailer, building material, or gasoline in exchange for services;
2. For self-employed applicants, gross business receipts minus business expenses; and
3. Unearned income.

**B.** A person whose income is counted. The Department shall include the income of the following persons under Section 1902(a)(17) of the Act if living together unless the person is a SSI cash recipient:
1. Applicant;
2. Applicant's parent, if the applicant is an unmarried dependent child, who is less than 18 years old;
3. Applicant's spouse;
4. The sponsor, under 8 CFR 213(a)(1), and sponsor's spouse of a person meeting the alien requirements under A.R.S. § 36-2903.03;
5. The non-parent caretaker relative and spouse, as allowed under R9-22-1420, and their unmarried minor children if applying as a family, which includes a dependent child living with a specified relative, under R9-22-1420;

**C.** Income exclusions. The Department shall exclude the following income:
1. Agent Orange settlement fund payments;
2. AmeriCorps Network Program benefits;
3. Burial benefits dispersed solely for burial expenses;
4. Cash contributions from other agencies or organizations so long as the contributions are not intended to cover the following items:
   a. Food;
   b. Rent or mortgage payments for shelter;
   c. Utilities;
   d. Household supplies, such as bedding, towels, laundry, cleaning, and paper supplies;
   e. Public transportation fares for personal use;
   f. Basic clothing or diapers; or
   g. Personal care and hygiene items, such as soap, toothpaste, shaving cream, and deodorant;
5. Disaster assistance provided under the Federal Disaster Relief Act, disaster assistance organizations, or comparable assistance provided by state or local governments;
6. Educational grants or scholarships funded by the United States Department of Education or from a Veterans Education assistance program or the Bureau of Indian Affairs student assistance program;
7. Energy assistance that is provided:
   a. Either in cash or in-kind by a government agency or municipal utility, or
   b. In-kind by a private nonprofit organization;
8. Earnings from high school on-the-job training programs;
9. Earned income of dependent children who are students enrolled and attending school at least half-time as defined by the institution;
10. Fair Labor Standard Act supplemental payment;
11. Food stamp benefits;
12. Foster care maintenance payments intended for children who are not included in the family or Medical Expense Deduction (MED) unit;
13. Funds set aside in an Individual Development Account under A.A.C. R6-12-404;
14. Governmental rent and housing subsidies;
15. Income tax refunds, including any earned income tax credit;
16. Loans from a private person, or a commercial or educational institution;
17. Nonrecurring cash gifts that do not exceed $30 per person in any calendar quarter;
18. Payments made from a fund established by the Susan Walker v. Bayer Corporation class action lawsuit or the Ricky Ray Hemophilia Relief Fund Act of 1998;
19. Radiation exposure compensation payments;
20. Reimbursement for work-related expenses which do not exceed the actual expense amount;
21. Reimbursement for Job Opportunities and Basic Skills (JOBS) Program training-related expenses;
22. Reparation and restitution payments under Section 1902(r) of the Act;
23. SSI designated account and interest earned on that account;

24. Temporary Assistance for Needy Families (TANF) or SSI cash assistance payment;
25. Vendor payment to a third-party to cover family expenses, if the payment is made by an organization or a person who is not a member of the family or MED unit;
26. Volunteers In Service To America (VISTA) income that does not exceed the state or federal minimum wage;
27. Vocational rehabilitation program payments made as reimbursement for training-related expenses, subsistence and maintenance allowances, and incentive payments that are not intended as wages;
28. Women, Infants, and Children (WIC) benefits; or
29. Any other income specifically excluded under 20 CFR Part 416 Appendix K.

**D.** Special income provision for child support. The Department shall consider child support to be income of the child for whom the support is intended and count the child support income received after deducting $50 per child receiving child support income from the monthly amount.

**E.** Determining income for a month.
1. Calculating monthly income. The Administration or its designee shall calculate monthly income under R9-22-1419.01 through 1419.04.
2. The Administration or its designee shall deduct the applicable disregards and deductions to which a person is entitled for the month.

**F.** Earned Income Disregards.
1. General. The Department shall apply the earned income disregards to each employed person's gross earnings.
2. Disregards. The Department shall apply the following method to calculate the amount of the countable earned income:
   a. Subtract a $90 cost of employment (COE) allowance from the gross amount of earned income for each person whose earned income is counted;
   b. Subtract an amount billed for the care of each dependent child or incapacitated adult member who is the responsibility of the person whose income is counted, if the care is for the purpose of allowing the person to work, not to exceed:
      i. For a wage-earner employed full-time (86 hours or more a month), $200 for each child less than age two, and $175 for each other dependent; and
      ii. For a wage earner employed part-time (less than 86 hours a month), $100 for each child less than age two, and $88 for each other dependent.
3. Loss of disregards. The Department shall not apply the earned income disregards if the member fails to report to the Department a change in income within 10 days from the date the change becomes known to the member. The change report to the Department shall be postmarked no later than the 10th day from the date the change becomes known.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4).

**R9-22-1419.01. Income Eligibility**

**A.** A person is not eligible under this Article unless the person's monthly income is equal to or below the appropriate Federal Poverty Level (FPL) listed in R9-22-1420 and R9-22-1421. A person is not eligible under R9-22-1429 unless the person's income during the period defined in R9-22-1429(C) is equal to or below the FPL under R9-22-1429(B).

**B.** Definitions.
1. "Monthly income" means the gross income received or projected to be received during the month or the monthly equivalent.
2. "Monthly equivalent" means a monthly income amount established by averaging, prorating, or converting a person's income.

**Historical Note**
New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4).

**R9-22-1419.02. Methods for Calculating Monthly Income**

**A.** Projecting income.
1. Description. Projecting income is a method of determining the amount of income that a person will receive.
2. Calculation. The Administration or designee shall project income by:
   a. Converting income to a monthly equivalent,
   b. Using unconverted income, or
   c. Prorating income to determine a monthly equivalent.
3. Exclusion. When calculating projected monthly income, the Administration or designee shall exclude an unusual variation in income, except for a month in which the variation is anticipated to occur.

**B.** Unconverted income.
1. Description. Unconverted income is the actual amount of income received or projected to be received during a month.
2. Calculation. The Administration or designee shall sum the actual amount of income received or projected to be received during a month.

**C.** Converted income.
1. Description. Converted income is income received weekly or biweekly that is changed to a monthly equivalent.
2. Calculation.
   a. To convert income, the Administration or designee shall determine the average weekly or bi-weekly income amount before converting to the monthly equivalent if the person's past income fluctuates and the fluctuation is expected to recur.
   b. To convert income paid weekly to a monthly equivalent, the Administration or designee shall multiply the weekly average by 4.3 weeks.
   c. To convert income paid bi-weekly to a monthly equivalent, the Administration or designee shall multiply the bi-weekly average by 2.15 weeks.

**D.** Averaged income.
1. Description. Averaging income proportionally distributes the person's income received on a regular basis.
2. Calculation. To average income, the Administration or designee shall add the amount of the income and divide by the total number of pay periods. If the amount of income received per pay period fluctuates, and the fluctuation is expected to continue, the Administration or designee shall:
   a. Use the averaged weekly or bi-weekly amounts to convert weekly or bi-weekly income to a monthly equivalent;
   b. Use the averaged monthly or semi-monthly amounts to project monthly income; and

c. Use the averaged hours worked and multiply the average by the current rate of pay. If there is a change in the rate of pay; use the new rate of pay when calculating projected income under subsection (A).

**E.** Prorated income.
1. Description. Prorated income evenly distributes a person's income over the period the income is intended to cover to calculate a monthly equivalent.
2. Calculation. To prorate income, the Administration or designee shall divide the total amount of the person's income received during the period by the number of months that the income is intended to cover.

**Historical Note**
New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4).

**R9-22-1419.03. Calculations and Use of Methods Listed in R9-22-1419.02 Based on Frequency of Income**

**A.** Monthly income. If income is received monthly or in a lump sum, the Administration or designee shall use the unconverted method for calculating monthly income. Lump sum means a non-recurring payment that serves as a complete payment. Lump sum payments include but are not limited to: rebates or credits; inheritances; insurance settlements; and payments for prior months from such sources as Social Security, Veterans Administration, Railroad Retirement, child support arrearages, or other benefits. A lump sum payment may include a portion intended for the current month.

**B.** Weekly income. If income is received weekly the Administration or designee shall convert the income to a monthly equivalent.

**C.** Bi-weekly income. If income is received bi-weekly the Administration or designee shall convert the income to a monthly equivalent.

**D.** Semi-monthly or daily income. If income is received semi-monthly or daily, the Administration or designee shall use the unconverted method for calculating monthly income.

**E.** Bimonthly, quarterly, semi-annual, or annual income. If income is received bimonthly, quarterly, semi-annually or annually, the Administration or designee shall prorate the income received or projected to be received.

**Historical Note**
New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4).

**R9-22-1419.04. Exceptions to R9-22-1419.03**

**A.** New income.
1. Description. New income is income received from a new source during the first calendar month that the income is received from the source.
2. Calculating monthly income.
   a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1419.03 to calculate the monthly income.
   b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.

**B.** Terminated income.
1. Description. Terminated income is income received during the last calendar month that income is received from a source when no more income is expected to be received.
2. Calculating monthly income.
   a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1419.03 to calculate the monthly income.
   b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.

**C.** Break in income.
1. Description. A break in income is:
   a. Income received from a previous source in the first calendar month following a break in established frequency of income from the source of one calendar month or more, or
   b. Income received from a source in the last calendar month before a break in established frequency of income of one calendar month or more.
2. Calculating monthly income.
   a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1419.03 to calculate the monthly income.
   b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.

**D.** Contract income.
1. Description. Contract income is income a person earns under a contract or other legal document that specifies a length of time the contract or legal document covers, the amount of income to be paid, and the frequency of payment.
2. Calculating monthly income.
   a. The Administration or designee shall calculate the monthly income based on the frequency of payment if income is paid more frequently than monthly.
   b. The Administration or designee shall prorate over the period of time specified by the contract if income is paid monthly or less frequently.

**E.** Unusual variation in the amount of income.
1. Description. Unusual variation is an amount of income that is different from the established amount received and is not projected to continue or recur.
2. Calculating monthly income.
   a. When calculating income for the month in which an unusual variation in income occurs, the Administration or designee shall include the unusual variation in the income calculation.
   b. When an unusual variation in income occurs during the month, the Administration or its designee shall use the converted method for calculating monthly income if income is received weekly or bi-weekly.
   c. When projecting income for the months following the month in which the unusual variation occurs, the Administration or designee shall exclude the unusual variation in income from the income calculation.

**Historical Note**
New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4).

**R9-22-1420. Eligibility For a Family**

**A.** The Department shall determine eligibility for AHCCCS medical coverage for a family unit when the requirements under this Section are met.

**B.** The family unit shall include the following when living together:
1. A natural or adopted dependent child under age 18,
2. A dependent child age 18, who is:
   a. A full-time student at a secondary school; or

b. Attending a vocational or technical training school which includes shop practicum for at least 30 hours per week or does not include shop practicum and attendance is at least 25 hours per week; and
c. Reasonably expected to complete the education or training before age 19; and
3. A natural or adoptive parent of a dependent child.
4. An unborn child of a person in the family unit.

**C.** The Department shall include the spouse of the dependent child's parent if the spouse wants to apply for AHCCCS medical coverage.

**D.** The Department shall include the dependent child's non-parent caretaker relative and the spouse of the non-parent caretaker relative, if the non-parent caretaker relative wants to apply for AHCCCS medical coverage and:
1. Provides a dependent child with:
a. Physical care,
b. Support,
c. Guidance, and
d. Control; and
2. The parent of a dependent child:
a. Does not live in the non-parent caretaker relative's home;
b. Lives with the non-parent caretaker relative but is also a dependent child; or
c. Lives with the non-parent caretaker relative but cannot function as a parent due to physical or mental impairment.
3. The Department shall not include a SSI-cash recipient in the family unit.

**E.** Income standard. The family unit's countable income shall not exceed 100 percent FPL adjusted annually based on the number of persons in the family unit.

**F.** Continued medical coverage. An eligible member of the family unit under this Section may be entitled to continued AHCCCS coverage for up to 24 months if eligible under subsection (F)(3)(a) and up to four months if eligible under subsection (F)(3)(b) if the family unit's income exceeds the 100 percent FPL and the following conditions are met:
1. The family continues to include a dependent child,
2. The family received AHCCCS medical coverage for three calendar months out of the most recent six months, and
3. The loss of AHCCCS coverage is due to:
a. Increased earned income of the caretaker relative and the person is a member of the family unit in accordance with 42 U.S.C.1396a(e)(1) and 42 U.S.C.1396r-6, or
b. Increased spousal or child support and the family unit member meets requirements under 42 CFR 435.115(f) and Section 1931(c) of the Act.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1421. Eligibility For A Person Not Eligible As A Family**
Income standards. A person who is not approved in a family unit under R9-22-1420 but meets all the eligibility requirements in the Article is eligible for AHCCCS medical coverage if income does not exceed the following FPL levels adjusted annually:
1. 140 percent for a pregnant woman or a child under one year of age,
2. 133 percent for a child age one through five years of age, or
3. 100 percent for all other persons.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1422. Eligibility For a Newborn**
A child born to a mother eligible and receiving medical coverage under this Article, Article 15, and 9 A.A.C. 22, is automatically eligible for AHCCCS medical coverage for a period not to exceed 12 months if the child continuously lives with the mother in the state of Arizona. Eligibility begins on the child's date of birth and ends with the last day of the month in which the child turns age one. The Department shall conduct an informal review at six months to ensure the child resides with the mother in Arizona.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1423. Extended Medical Coverage For A Pregnant Woman**

**A.** A pregnant woman who applies for and is determined eligible for AHCCCS medical coverage during the pregnancy remains eligible throughout the 60-day postpartum period.

**B.** The postpartum period begins the day the pregnancy terminates and ends the last day of the month in which the 60th day falls.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1424. Family Planning Services Extension Program**

**A.** Except as under this Section, a person may receive family planning services as provided in A.R.S. § 36-2907.04.

**B.** The Administration shall deny or terminate family planning services under this Section for any of the following reasons:
1. Voluntary withdrawal,
2. Loss of contact,
3. Failure to provide information,
4. Incarceration,
5. Move out-of-state
6. Sterility, or
7. Death.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1425. Young Adult Transitional Insurance**
A person under the age of 21 who was in foster care under the responsibility of the state on their 18th birthday is eligible for AHCCCS medical coverage under § 36-2901.6(a)(iii).

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1426. Special Groups For Children**

The Administration shall provide AHCCCS medical coverage to children eligible for Title IV-E adoption subsidy or Title IV-E foster care under 42 CFR 435.145 and children eligible for state adoption subsidy under 42 CFR 435.227.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1427. Eligibility For a Person With Medical Bills Whose Income is Over 100 percent FPL**

An applicant who is not eligible for AHCCCS medical coverage due to excess income may become AHCCCS eligible by deducting medical expenses from their income. This coverage is called Medical Expense Deduction (MED).

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1428. MED Family Unit**

**A.** For the purpose of this subsection, a child is an unmarried person under age 18.

**B.** The Department shall consider each of the following to be a family when living together:
1. A parent and that parent's minor children,
2. A married couple without minor children,
3. A married couple and the minor children of either or both spouses,
4. Unmarried parents who live with minor children in common, and their minor children, whether in common or not, or
5. A person without children.

**C.** If an applicant is pregnant, the family unit shall be increased by the number of unborn.

**D.** When a child in the MED family unit is a parent of children, who live with that child, the Department shall include the child's children in the family.

**E.** The Department shall not include a SSI-cash recipient in the MED family unit even if a SSI-cash recipient is a parent, spouse or child.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1429. MED Income Eligibility Requirements**

**A.** Income exclusions. The exclusions in R9-22-1419(C) apply to the MED family unit.

**B.** Income standard.
1. The Department shall divide the annual FPL for the MED family unit that is in effect during each month of the income period by 12 to determine the monthly FPL.
2. The Department shall add the monthly FPLs for the income period and multiply the resulting amount by 40 percent.
3. Changes made to the annual FPL will be made effective in April each year.

**C.** Income period. The income period is the month of application and the next two months. The Department shall add together the three months' income to establish the MED family unit's income amount.

**D.** Medical expense deduction period. The medical expense deduction period is a three month period consisting of the month before the application month, the month of application, and month following the application month.

**E.** The Department shall calculate the amount of countable monthly income as follows:
1. Subtract a $90 cost of employment allowance from the gross amount of earned income for each person whose earned income is counted,
2. Subtract from the remaining earned income an amount billed by the child care provider for the care of each dependent child under age 18 or incapacitated adult member of the MED family unit for the purposes to allow the person to work, not to exceed:
   a. $200 for a child under age two and $175 for the other dependents for a wage-earner employed full-time (86 or more hours per month); and
   b. $100 for a child under age two, and $88 for the other dependents for a wage earner employed part-time (less than 86 hours a month);
3. Add the remaining earned income for each MED family member to the unearned income of all MED family members;
4. Compare the MED family's unit countable income amount to the income standard in subsection (B). The difference is the amount of medical expenses the family shall incur during the medical expense deduction period to become eligible;
5. Subtract allowable medical expense deductions which were incurred by:
   a. A member of the MED family unit;
   b. A deceased spouse or minor child of a MED family unit if this person would have been a member of the MED unit during the MED expense deduction period;
   c. A person who was a minor child of a MED family unit member when the expense was incurred but who is no longer a minor child; or
   d. A minor child who left home prior to the date of application to live with someone other than a parent. This includes a child who is a runaway;
6. Compare the net MED family income to the income standard listed in subsection (B); and
7. Family is eligible if the net income in subsection (6) does not exceed the income standard in subsection (B).

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1430. MED Resource Eligibility Requirements**

**A.** Include countable resources. The Department shall include the countable resources belonging to and available to members of the family, and sponsor and sponsor's spouse of a person who is a qualified alien under A.R.S. § 36-2903.03.

**B.** Ownership and availability. The Department shall evaluate the ownership of resources to determine the availability of resources to a person listed in subsection (A).
1. Jointly owned resources, with ownership records containing the words "and" or "and/or" between the owners' names, are available to each owner except if one of the owners refuses to sell. A consent to sale is not required if all owners are members of the MED family unit.
2. Jointly owned resources, with ownership records containing the word "or" between the owners' names, are pre-

sumed to be available in full to each owner. The applicant or member may rebut the presumption by providing clear and convincing evidence of intent to establish a different type of ownership. If the presumption is rebutted, the resource is available to the owners:
a. Consistent with the intent of the owners, or
b. Based on each owner's proportionate net contribution if there is not clear and convincing evidence of a different allocation.
3. The availability of a trust shall be established under 42 U.S.C. 1396p(d)(4)(A) or (C).

**C.** Unavailability. The Department shall consider the following resources unavailable:
1. Property subject to spendthrift restriction which may include:
a. Accounts established by the SSA, Veteran's Administration, or similar sources which mandate that the funds in the account be used for the benefit of a person not residing with the MED family unit; or
b. Trusts established by a will or funded solely by the income and resources of someone other than a member of the MED family unit.
2. A resource being disputed in divorce proceedings or in probate matters;
3. Real property located on a Native American reservation;
4. A resource held by a conservator are unavailable to the extent court imposed restrictions make the resource unavailable to the applicant, member, or member of the family unit for:
a. Medical care,
b. Food,
c. Clothing, or
d. Shelter.

**D.** Resource exclusion. The Department shall exclude the following resources:
1. One burial plot for each person listed in R9-22-1428;
2. Household furnishings and personal items which are necessary for day-to-day living;
3. Up to $1500 of the value of one prepaid funeral plan, for each person listed in R9-22-1428, that specifically covers only funeral-related expenses as evidenced by a written contract;
4. The value of one motor vehicle regularly used for transportation. If the MED family unit owns more than one vehicle, the exclusion is applied to the vehicle with the highest equity value. The equity value of all remaining vehicles is counted toward the resource standard in subsection (F), subject to the limitations described in this Section;
5. A vehicle used to earn income and not simply transportation to and from employment;
6. The value of any vehicle in which the SSI-cash recipient has an ownership interest;
7. The value of any vehicle used for medical treatment, employment, or transportation of a SSI-cash disabled child, and which is excluded by SSI for that reason;
8. Funds set aside in an Individual Development Account under 6 A.A.C.12 Article 4; and
9. Any other resource specifically excluded by federal law.

**E.** Calculation of resources. The Department shall determine the value of all household resources as follows:
1. Calculate the total amount of the liquid resources;
2. Calculate the equity value of each non-liquid resource. The Department shall determine the equity value of a non-liquid resource by subtracting the amount of valid encumbrances on that resource from:
a. The market value of real property if the assessor's value of real property does not include the value of permanent structures on that property, or there is no assessor's evaluation of the property;
b. The assessor's full cash value as the value of all other real property,
c. The market value of all other nonliquid resources; and
d. The equity value of a resource shall not be less than zero.
3. Determine the MED family unit's resources by adding the totals determined in subsections (1) and (2).

**F.** Resource standard. The resources determined in subsection (E) shall not exceed $100,000 of which no more than $5,000 shall be liquid assets.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1431. MED Effective Date of Eligibility**

**A.** The MED family unit is eligible on the day the income and resource eligibility requirements are met but no earlier than the first day of the month of application. If the family unit meets the income criteria in the application month but does not meet the resource limit until the following month, the family unit's effective date of eligibility is the first day of the month following the month of application.

**B.** The Department shall adjust the effective date of eligibility to an earlier date if:
1. A member presents verification of additional allowable medical expenses incurred on an earlier date during the medical expense deduction period, and
2. A member presents the verification within 60 days of the approval of eligibility under this Section.

**C.** The Department shall not adjust an effective date of eligibility more than one time per application.

**D.** The Department shall adjust the effective date no later than 30 days after the end of the 60 day period.

**E.** The Department shall deny the application and provide the applicant a denial notice when an applicant does not meet the MED requirements under this Article during the month of application or the month following the month of application.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1432. MED Eligibility Period**

Eligibility shall be approved for six months with changes in circumstances not affecting eligibility for the first three months.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1433. Eligibility Appeals**

**A.** Adverse actions. An applicant or member may appeal and request a hearing concerning any of the following adverse actions:
1. Complete or partial denial of eligibility;
2. Suspension, termination, or reduction of AHCCCS medical coverage; or

3. Delay in the eligibility determination beyond the timeframes under this Article.

**B.** Notice of Action. The Department shall personally deliver or mail, by regular mail, a Notice of Action to the person affected by the action. For the purpose of this Section, the date of the Notice of Action shall be the date of personal delivery to the applicant or the postmark date, if mailed.

**C.** Automatic adjustments. An applicant or a member is not entitled to a hearing to challenge changes made automatically as a result of changes in federal or state law, unless the Department has incorrectly applied the law to the person seeking the hearing.

**D.** Hearings to the Department of Economic Security. An applicant or member may request a hearing from the Department. The Department shall conduct the hearing in accordance with the Department's appeal procedures under A.A.C. R6-12-1002, R6-12-1003, and R6-12-1005 through R6-12-1013. For purposes of this Section, any references in the Department's rules to the word "benefits" shall refer to AHCCCS medical coverage, any reference to the cash assistance program shall refer to the AHCCCS medical coverage, and references to cash overpayments are not applicable.

**E.** Stay of adverse action pending appeal and exceptions.
1. If an appellant files a request for appeal within 10 days after the date of the Notice of Action, the Department shall not impose the adverse action and shall continue AHCCCS medical coverage at the current level unless:
   a. The appellant specifically waives continuation of current benefits, or
   b. The appeal results from a change in federal or state law which mandates an automatic adjustment for all classes of recipients and does not involve a misapplication of the law;
2. The Department shall not impose the adverse action until receipt of an official written decision from the hearing officer except in the following circumstances:
   a. If the agency mails the notice as required under R9-22-1411 and R9-22-1413 and the member does not request a hearing before the date of action,
   b. At the hearing and on the record, the hearing officer finds that:
      i. The sole issue involves application of law,
      ii. The Department properly applied the law, and
      iii. The Department determined the correct level of assistance for the appellant;
   c. A change in eligibility occurs for a reason other than the issue on appeal, and the member receives and fails to timely appeal a Notice of Action concerning the change;
   d. Federal or state law mandates an automatic adjustment for classes of recipients;
   e. The appellant withdraws the request for hearing; or
   f. The appellant fails to appear for a scheduled hearing without prior notice to the Department's Office of Appeals, and the hearing officer does not rule in favor of the appellant based upon the record.
3. An appellant whose AHCCCS medical coverage has been continued may be financially liable for all AHCCCS medical coverage received during a period of ineligibility if the Department finds in favor of a discontinuance decision.
4. If the appellant files a request for appeal more than 10 days after, but within 20 days of the date of the Notice of Action, the Department may impose the adverse action while the appeal is pending.

**F.** Retroactive eligibility. If the Department's Office of Appeals hearing decision finds in favor of the appellant, eligibility is retroactive to the date of discontinuance or the first day the person would have otherwise been eligible under this Article.

**G.** Further Appeal and Review of Hearing Decisions.
1. An appellant may appeal the hearing decision to the Department's Appeals Board under A.A.C. R6-12-1014.
2. The Appeals Board shall issue a final written decision to the appellant under A.A.C. R6-12-1015.
3. The parties may seek judicial review of the final written decision of the Appeals Board under Title 41, Chapter 14, Article 3, Arizona Revised Statutes. The Appeals Board's final decision shall identify the appellant's right to seek judicial review.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1434. State Emergency Services Program (SESP)**

**A.** General Information.
1. The Department shall determine an applicant's eligibility for SESP when an applicant is not eligible under R9-22-1418 and:
   a. Meets the eligibility criteria under subsection (B), and R9-22-1405, R9-22-1406, R9-22-1410, R9-22-1416, and R9-22-1417, or
   b. Meets the MED eligibility criteria under R9-22-1427 through R9-22-1431.
2. The following rules shall also apply under this Section: R9-22-1401 through R9-22-1404, R9-22-1407 through R9-22-1409, R9-22-1411(A), R9-22-1413 through R9-22-1415, R9-22-1419 and R9-22-1433.

**B.** Income standard.
1. The family unit's countable income under this Section shall not exceed 40 percent FPL adjusted annually based on the number of persons in the family unit under A.R.S. § 36-2901.06.
2. The Department shall consider the following to be a family unit for purposes of this Section:
   a. A single person without children,
   b. A married couple without children, or
   c. A MED family unit under R9-22-1428.
3. The Department shall calculate income under R9-22-1419 or R9-22-1429.

**C.** Notice for Approval or Denial. The Department shall send an applicant a written notice of the eligibility decision under this Section. This notice shall include a statement of the intended action, and:
1. If approved under SESP, the notice shall also contain:
   a. The effective date of eligibility;
   b. A statement detailing the reason for the denial of full services;
   c. The legal authority supporting the decision;
   d. Where the legal authority supporting the decision can be found;
   e. An explanation of the right to request a hearing; and
   f. The date by which a request for hearing shall be received by the Department.
2. If denied, the notice shall contain:
   a. The effective date of the denial;
   b. The reason for the denial, including specific financial calculations and the financial eligibility standard if applicable;
   c. Legal authority supporting the decision;

d. Where the legal authority supporting the decision can be found;
e. An explanation of the right to request a hearing; and
f. The date by which a request for hearing shall be received by the Department.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4).

**R9-22-1435. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1436. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

## ARTICLE 15. AHCCCS MEDICAL COVERAGE FOR PEOPLE WHO ARE AGED, BLIND, OR DISABLED

**R9-22-1501. General Information**

**A.** General. The Administration shall determine eligibility for AHCCCS medical coverage for the following applicants or members using the eligibility criteria and requirements in this Article:
1. A person who is aged, blind, or disabled and does not receive SSI cash under 42 CFR 435.210; and
2. A person terminated from the SSI cash program under R9-22-1505.

**B.** Confidentiality. The Administration shall maintain the confidentiality of the person's records and shall not disclose the person's financial, medical, or other confidential information except under Article 5 of this Chapter.

**C.** Application process.
1. A person may apply for AHCCCS medical coverage by submitting a signed application to any Administration office or outstation location under R9-22-1405.
2. The provisions in R9-22-1405(B), (C), and (E) apply to this Section.
3. The application date is the date a signed application is received at any Administration office or outstation location approved by the Director.
4. An applicant who files an application may withdraw the application, either orally or in writing. If an applicant withdraws an application, the Administration shall send the applicant a denial notice under subsection (F).
5. Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 90 days for an applicant applying on the basis of disability and 45 days for all other applicants.
6. If an applicant dies while an application is pending, the Administration shall complete an eligibility determination for the deceased applicant.
7. The Administration shall complete an eligibility determination on an application filed on behalf of a deceased applicant, if the application is filed in the month of the applicant's death.

**D.** Redetermination of eligibility for a person terminated from the SSI cash program.
1. Continuation of AHCCCS medical coverage. The Administration shall continue AHCCCS medical coverage for a person terminated from the SSI cash program until a redetermination of eligibility under subsection (D)(2) is completed.
2. Coverage group screening. The Administration shall screen for eligibility under any coverage group under A.R.S. §§ 36-2901(6)(a)(i) and (ii) and 36-2934.
   a. If an applicant files an application for Arizona Long-Term Care System (ALTCS) coverage, the Administration shall determine eligibility under 9 A.A.C. 28, Article 4.
   b. If an applicant or member is aged, blind, or disabled, but not in need of long-term care services, the Administration shall determine eligibility under this Article.
   c. For all other persons, the Administration shall refer the applicant's case to the Department for an eligibility decision under Article 14.
3. Eligibility decision.
   a. If an applicant is eligible under this Article or 9 A.A.C. 28, Article 4, the Administration shall send a notice as under subsection (F) informing the applicant that AHCCCS medical coverage shall continue.
   b. If an applicant is ineligible, the Administration shall send a notice as under subsection (F) to discontinue AHCCCS medical coverage.

**E.** Eligibility effective date. Eligibility is effective on the first day of the month that all eligibility requirements are met, but no earlier than the month of application.

**F.** Notice for approval or denial. The Administration shall send an applicant a written notice of the decision regarding the application. This notice shall include a statement of the intended action, and:
1. If approved, the notice shall contain the effective date of eligibility.
2. If approved under FESP, the notice shall also contain:
   a. The emergency services certification end date,
   b. A statement detailing the reason for the denial of full services,
   c. The legal authority supporting the decision,
   d. Where the legal authority supporting the decision can be found,
   e. An explanation of the right to request a hearing, and
   f. The date by which a request for hearing shall be received by the Administration.
3. If denied, the notice shall contain:
   a. The effective date of the denial;
   b. The reason for the denial, including specific financial calculations and the financial eligibility standard, if applicable;
   c. Legal authority supporting the decision;
   d. Where the legal authority supporting the decision can be found;
   e. An explanation of the right to request a hearing; and
   f. The date by which a request for hearing shall be received by the Administration.

**G.** Reporting and verifying changes.
1. A member shall report to the Administration the following changes for an applicant or a member, an applicant's or member's spouse, and an applicant or member's dependent children:
   a. Change of address;
   b. Change in the household's members;

c. Change in income;
d. Change in resources, when applicable;
e. Determination of eligibility for other coverage;
f. Death;
g. Change in marital status;
h. Change in school attendance;
i. Change in Arizona state residency; and
j. Any other change that may affect the member's or applicant's eligibility.

2. A member shall report to the Administration the following changes for an applicant or a member:
a. Admission to a penal institution,
b. Change in U.S. citizenship or immigrant status,
c. Receipt of a Social Security number, and
d. Change in first- or third-party liability which may contribute to the payment of all or a portion of the person's medical costs.

3. A person shall report a change to the Administration either orally or in writing and shall include the:
a. Name of the affected applicant or member;
b. Description of the change;
c. Date the change occurred;
d. Name of the person reporting the change; and
e. Social Security or case number of the applicant or member, if known.

4. A person shall provide verification of changes if requested by the Administration.

5. A person shall report anticipated changes in eligibility to the Administration as soon as the person knows that the change will occur.

6. A person shall report an unanticipated change to the Administration within 10 days following the date the change occurred.

**H.** Processing of changes and redeterminations. If a member receives AHCCCS medical coverage under subsection (A), the Administration shall redetermine the member's eligibility at least once every six months or more frequently when changes occur that may affect eligibility.

**I.** Actions that may result from a redetermination or change. The processing of a redetermination or change shall result in one of the following actions:
1. No change in eligibility,
2. Discontinuance of eligibility if a condition of eligibility is no longer met, or
3. A change in the program under which a person receives AHCCCS medical coverage.

**J.** Notice of discontinuance.
1. Contents of notice. The Administration shall issue a notice whenever it takes an adverse action to discontinue a member's eligibility. The notice shall contain the following information:
a. A statement of the action that is being taken;
b. The effective date of the action;
c. The reason for the discontinuance, including specific financial calculations and the financial eligibility standard if applicable;
d. The legal authority that supports the action proposed by the Administration;
e. Where the legal authority supporting the decision can be found;
f. An explanation of the right to request a hearing; and
g. The date by which a hearing request shall be received by the Administration and the right to continue medical coverage pending appeal.

2. Advance notice of changes in eligibility. Advance notice means a notice of proposed action that is issued to the member at least 10 days before the effective date of the proposed action. Except under subsection (J)(3), advance notice shall be issued whenever an adverse action is taken to discontinue eligibility.

3. Exceptions from advance notice. A notice shall be issued to a member to discontinue eligibility no later than the effective date of the action if:
a. The member provides to the Administration a clearly written statement, signed by that member, that:
i. Services are no longer wanted; or
ii. Gives information that requires termination or reduction of services and indicates that the member understands that this is the result of supplying that information;
b. The member provides information to the Administration that requires termination of eligibility and a member signs a written statement waiving advance notice;
c. The member cannot be located and mail sent to the member's last known address has been returned as undeliverable subject to reinstatement of discontinued services under 42 CFR 231(d);
d. The member has been admitted to a public institution where a person is ineligible for coverage;
e. The member has been approved for Medicaid in another state; or
f. The Administration receives information confirming the death of the member.

**K.** Request for hearing. An applicant or member may request a hearing under Article 8 of this Chapter for any of the following adverse actions:
1. Complete or partial denial of eligibility;
2. Termination or reduction of AHCCCS medical coverage; or
3. Delay in the eligibility determination beyond the timeframes listed in R9-22-1501(C).

**L.** Assignment of rights. A person determined eligible assigns rights to all types of medical benefits to which the person is entitled under operation of law under A.R.S. § 36-2903.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 23, effective December 9, 2003 (Supp. 03-4).

### R9-22-1502. General Eligibility Criteria

**A.** Social Security Number.
1. An applicant applying under R9-22-1501(A)(1), (A)(2), and R9-22-1505(A) shall furnish a SSN or apply for one, under 42 CFR 435.910 and 435.920.
2. An applicant who meets all other eligibility criteria except those in subsection (C) shall provide a SSN unless the applicant cannot legally obtain one.
3. If an applicant cannot recall or has not been issued a SSN, the Administration shall assist in obtaining or verifying the applicant's SSN under 42 CFR 435.910.

**B.** State Residency. As a condition of eligibility, a person shall be a resident of Arizona under 42 CFR 435.403.

**C.** Citizenship and Immigrant Status.
1. As a condition of eligibility for full services under Article 2, an applicant or member shall be a citizen of the United

States, or shall meet requirements for qualified alien under A.R.S. §§ 36-2903.03(A) and 36-2903.03(B), or A.R.S. § 36-2903.03(C).

2. An applicant is eligible for emergency medical services defined in R9-22-217 when the applicant is either a qualified alien or noncitizen:
   a. Meets all other eligibility requirements, except those in subsection (1), and
   b. Is eligible under A.R.S. §§ 36-2901(6)(a)(i), 36-2901(6)(a)(ii), or 36-2901(6)(a)(iii).

**D.** Applicant and Member Responsibility. As a condition of eligibility, an applicant and member shall:

1. An applicant and member shall authorize the Administration to obtain verification.
2. As a condition of eligibility, an applicant and member shall:
3. Give the Administration complete and truthful information. The Administration may deny an application or discontinue eligibility if:
   a. The applicant or member fails to provide information necessary for initial or continuing eligibility,
   b. The applicant or member fails to provide the Administration with written authorization to permit the Administration to obtain necessary verification,
   c. The applicant or member fails to provide verification after the Administration had made an effort to obtain the necessary verification but has not obtained the necessary information, or
   d. The applicant or member does not assist the Administration in resolving incomplete, inconsistent, or unclear information that is necessary for initial or continuing eligibility.
4. Comply with the DCSE under 42 CFR 433.148 in establishing paternity and enforcing medical support obligations when requested. The Administration shall not deny AHCCCS eligibility to any applicant who would otherwise be eligible and who is a minor child and whose parent or legal representative does not cooperate with the medical support requirements or first-and third-party liability under Article 10;
5. Provide information concerning third-party coverage for medical care;
6. Take all necessary steps to obtain annuity, pension, retirement, and disability benefits for which an applicant or member may be entitled.

**E.** Inmate of a public institution. An inmate of a public institution is not eligible for AHCCCS coverage if federal financial participation (FFP) is not available.

**F.** Verification of eligibility information.

1. The applicant or member has the primary responsibility to provide the Administration with verification for all information necessary to complete the determination of eligibility.
2. The Administration shall provide an applicant or member no less than 10 days following the date of written request for the information to provide required verification. If an applicant or member does not provide the required information timely, the Administration may deny the application or discontinue eligibility.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1503. Financial Eligibility Criteria**

**A.** General income eligibility. The Administration shall count the income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K with the following exceptions in (B).

**B.** Exceptions.

1. In-kind support and maintenance is excluded. In-kind support and maintenance is explained in 42 U.S.C. 1382a(a)(2)(A).
2. For a person living with a spouse, the computation rules for an eligible couple are followed for the net income calculation, even if the spouse is not eligible for or applying for SSI or coverage under this Article.
3. In determining the net income of a married couple living with a child or of a person who is not living with a spouse but living with a child, a child allocation is allowed as a deduction from the combined net income of the couple for each child regardless of whether the child is ineligible or eligible. For the purposes of this Section, a child means a person who is unmarried, natural or adopted, under age 18 or under age 22 if a full-time student. Each child's allocation deduction is reduced by that child's income, including public income maintenance payments, using the methodology under 20 CFR 416.1163(b)(1) and (2).
4. In determining the income deemed available to an applicant who is a child, from an ineligible parent or parents to an applicant who is a child, an allocation for each eligible or ineligible child of the parent is allowed as a deduction from the parent's income using the methodology under 20 CFR 416.1165(b) and each child's allocation is reduced by that child's income, including public income maintenance payments.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1504. Eligibility For A Person Who is Aged, Blind, or Disabled**

**A.** To be eligible for AHCCCS medical coverage an applicant shall meet the conditions of eligibility and requirements in this Article and meet one of the income tests described in subsections (B), (C), or the special requirements in R9-22-1505.

**B.** The Administration shall determine if the applicant's countable income, as described in Section R9-22-1503, is less than or equal to 100 percent of the SSI FBR, adjusted annually.

**C.** The Administration shall determine if the applicant's countable income, as described in Section R9-22-1503, without deducting the amount from earned income under 42 U.S.C. 1382a(b)(4)(B)(iii), is less than or equal to 100 percent FPL adjusted annually.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1505. Eligibility for Special Groups**

**A.** Special Groups.

1. A person, meeting the requirements in A.R.S. § 36-2903.03 who:
   a. Is aged, blind, or disabled under 42 CFR 435.520; 42 CFR 435.530; or 42 CFR 435.540;
   b. Received SSI cash or AHCCCS medical coverage under subsections (A)(1) through (A)(4) on or before August 21, 1996;

c. Was residing in the United States under color of law on or before August 21, 1996; and
d. Meets the requirements under this Article.

2. A disabled child (DC), under 42 U.S.C. 1396a(a)(10)(A)(i)(II). A disabled child is a child who:
a. Was receiving SSI cash benefits as a disabled child on August 22, 1996;
b. Lost SSI cash benefits effective July 1, 1997, or later, due to a disability determination under Section 211(d)(2)(B) of Subtitle B of P.L. 104-193;
c. Continues to meet the disability requirements for a child which were in effect on August 21, 1996; and
d. Meets the requirements under this Article.

3. A disabled adult child (DAC), under 42 U.S.C. 1383c(c), who:
a. Was determined disabled by the Social Security Administration before attaining the age of 22 years,
b. Became entitled to or received an increase in child's insurance benefits under Title II of the Social Security Act on the basis of blindness or disability,
c. Was terminated from SSI cash benefits due to entitlement to or an increase in Title II of the Social Security Act (DAC) income,
d. Meets the requirements under this Article, and
e. Is 18 years of age or older.

4. A disabled widow or widower (DWW), under 42 U.S.C. 1383c(d) who:
a. Is blind or disabled,
b. Is ineligible for Medicare Part A benefits,
c. Received SSI cash benefits the month before Title II of the Social Security Act (DWW) benefit payments began, and
d. Meets the requirements under this Article.

5. A person, under 42 CFR 435.135 who:
a. Is aged, blind, or disabled;
b. Receives benefits under Title II of the Social Security Act;
c. Received SSI cash benefits in the past;
d. Received SSI cash benefits and Title II of the Social Security Act benefits concurrently for at least one month anytime after April 1977;
e. Became ineligible for SSI cash benefits while receiving SSI and Title II of the Social Security Act concurrently; and
f. Meets the requirements under this Article.

**B.** Resource Criteria for Special Groups

1. Except as provided in subsection (2), resource eligibility is determined using the resource criteria in 42 U.S.C. 1382a(3), U.S.C. 1382b, and 20 CFR 416 Subpart L.
2. Exceptions. The value of the following resources is excluded from eligibility determination:
a. Household goods and personal effects;
b. Burial Insurance;
c. Assets that an applicant has irrevocably assigned to fund the expenses of a burial;
d. The value of all life insurance if the face value does not exceed $1,500 total per insured applicant and the policy has not been assigned to fund a burial plan or declaratively designated as a burial fund;
e. The equity value up to $1,500 of an asset to be used as a burial fund or a revocable burial arrangement if there is no irrevocable burial arrangement, and if an applicant remains continuously eligible, all appreciation in the value of such assets; and
f. The value of oil, mineral, and timber rights.
3. Resource limits. A person is not eligible if countable resources owned by the person exceed $2,000 for a person or $3,000 for a couple under 42 U.S.C. 1382(a)(3)(A) and (B).

**C.** Income for Special Groups

1. Except as provided in subsection (2), income eligibility is determined using the income criteria in R9-22-1503(A).
2. Exceptions to income for special groups.
a. For a person in the DAC coverage group, defined by R9-22-1505(A)(3), the applicant's Title II of the Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(c).
b. For a person in the DWW coverage group, defined by R9-22-1505(A)(4), the applicant's Title II of the Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(b) and (d).
c. For an applicant or member in the coverage group defined by R9-22-1505(A)(5), the portion of the applicant's or member's Title II of the Social Security Act benefits attributed to cost-of-living adjustments received by the applicant since the effective date of SSI ineligibility is disregarded in determining income eligibility under 42 CFR 435.135.

**D.** 100 percent FBR

As a condition of eligibility for all special groups, countable income shall be equal to or less than 100 percent of the SSI FBR, adjusted annually.

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1506. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1507. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1508. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

## ARTICLE 16. REPEALED

**R9-22-1601. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1602. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1603. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1604. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1605. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1606. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1607. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1608. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1609. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1610. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1611. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1612. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1613. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1614. Reserved**

**R9-22-1615. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1616. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1617. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1618. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1619. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1620. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1621. Reserved**

**R9-22-1622. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1623. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1624. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1625. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1626. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1627. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1628. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1629. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1630. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1631. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1632. Reserved**

**R9-22-1633. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1634. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1635. Reserved**

**R9-22-1636. Repealed**

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

## ARTICLE 17. ENROLLMENT

**R9-22-1701. Enrollment of a Member with an AHCCCS Contractor**

**A.** General Enrollment Requirements.

1. Except as provided in subsections (A)(3), (A)(4), and (C), a member, determined eligible under this Chapter and residing in an area served by more than one contractor, shall have freedom of choice in the selection of a contractor serving the member's GSA within 16 days from the date of the initial interview. A Native American member may select IHS or another available contractor.
2. If the member does not make a choice, the Administration shall auto-assign the member to IHS if the member is a Native American living on a reservation, a contractor based on family continuity, or the auto-assignment algorithm.
3. The Administration shall enroll a member with the member's most recent contractor of record, if available, if the member's period of ineligibility and disenrollment from the contractor of record is for a period of less than 90 days except if:
   a. The member no longer resides in the contractor's GSA;
   b. The contractor's contract is suspended or terminated;
   c. The member was previously enrolled with CMDP but at the time of re-enrollment the member is not a foster care child;
   d. The member chooses another contractor or chooses IHS, if available to the member, during the annual enrollment choice period; or
   e. The member was previously enrolled with a contractor but at the time of re-enrollment the member is a foster care child.

4. The Administration shall not enroll a member with a contractor if a member:
   a. Is eligible for the FESP under R9-22-1418 or SESP under R9-22-1434;
   b. Is eligible for a period less than 30 days from the date the Administration receives notification of a member's eligibility, except for a member who is enrolled with CMDP or IHS;
   c. Is eligible only for a retroactive period of eligibility, except for a member who is enrolled with IHS;
   d. Is not a Native American and resides in an area not served by a contractor; or
   e. Is a Native American and resides in an area not served by a contractor or IHS.

**B.** Fee-for-service coverage. A member not enrolled with a contractor under subsection (A)(4) shall obtain covered medical services from an AHCCCS-registered provider on a fee-for-service basis under Article 7:

**C.** Foster care child. The Administration shall enroll a member with CMDP if the member is a foster care child under A.R.S. § 8-512.

**D.** Family Planning Services Extension Program. A member eligible for the Family Planning Services Extension Program, as under R9-22-1424, shall remain enrolled with the member's contractor of record, or IHS.

**E.** Contractor or IHS enrollment change for a member.
1. The Administration shall change a member's enrollment if the member requests a change to an available contractor or IHS during an annual enrollment period. A Native American may change from an available contractor to IHS or from IHS to an available contractor at any time.
2. The Administration shall approve a change for an enrolled member under this Article, or as determined by the Director.
3. The Administration shall approve a change in enrollment for any member if the change is a result of the final outcome of a grievance under Article 8.
4. A member may choose a different contractor if the member moves into a GSA not served by the current contractor or if the contractor is no longer available. If the member does not select a contractor, the Administration shall auto-assign the member as provided in subsection (A)(2).

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct a typographical error, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4).

**R9-22-1702. Effective Date of Enrollment with a Contractor and Notification to the Contractor**

**A.** Effective date of enrollment. A member's date of enrollment is the date enrollment action is taken by the Administration.

**B.** Financial liability of the contractor. The contractor shall be financially liable for an enrolled member's care as specified in contract.

**C.** Notice to contractor. The Administration shall notify the contractor of each member's enrollment with the contractor as specified in contract.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1703. Newborn Enrollment**

**A.** General.
1. The Administration shall enroll a newborn child of an AHCCCS eligible mother with a contractor or IHS, based on the mother's enrollment.
2. The Administration shall auto-assign a newborn child of an AHCCCS eligible mother who is not enrolled with a contractor or who is enrolled with CMDP.
3. The Administration shall notify the mother of the right to choose a different contractor for her child within 16 days from the date of the initial interview.

**B.** Financial liability for all newborns. The contractor shall be financially liable for the medical care of a newborn as specified in contract.

**C.** Notification to mother. The Administration shall notify the mother of the newborn's enrollment.

**D.** Choice. The Administration shall give the mother of the newborn an opportunity to select a different contractor or IHS, if available, for the newborn.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1704. Guaranteed Enrollment Period**

**A.** General. Except for members enrolled with IHS or CMDP, the Administration shall provide a guaranteed enrollment period for a one time period which begins on the effective date of the member's initial enrollment with the contractor and ends on the last day of the fifth full calendar month.

**B.** Exceptions to guaranteed period. The Administration shall not grant a guaranteed enrollment period or shall terminate a guaranteed enrollment period as provided in subsection (C), if the member:
1. Was factually ineligible when initially enrolled with the contractor,
2. Except as provided in 9 A.A.C. 22, Article 12, is an inmate of a public institution as defined in 42 CFR 435.1009,
3. Dies,
4. Moves out-of-state,
5. Voluntarily withdraws from the AHCCCS program, or
6. Is adopted.

**C.** Disenrollment effective date. The Administration shall terminate any guaranteed enrollment period to which the member is not entitled effective on:
1. The date the member is admitted to a public institution under subsection (B);
2. The member's date of death;
3. The last day of the month in which the Administration receives notification that a member moved out-of-state;
4. The date the Administration receives written notification of the member's voluntary withdrawal from the AHCCCS program; or
5. The date adoption proceedings are initiated through a private party, if known, or on the last day of the month in which the Administration receives notification of the proceedings.

**D.** Retroactive adjustments. The Administration shall adjust the member's eligibility and enrollment retroactively as under subsection (C).

**Historical Note**
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct a typographical error, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4).

## ARTICLE 18. RESERVED

## ARTICLE 19. FREEDOM TO WORK

*Article 19, consisting of Sections R9-22-1901 through R9-22-1922, made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).*

### R9-22-1901. General Freedom to Work Requirements

Under 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and (XVI), the Administration shall determine eligibility for AHCCCS medical services, under Article 2 of this Chapter, using the eligibility criteria and requirements under this Article for an applicant or member who is:

1. At least 16 years of age, but less than 65 years of age,
2. Employed, and
3. Not income eligible under A.R.S. § 36-2901(6)(a).

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

### R9-22-1902. General Administration Requirements

The Administration shall comply with the confidentiality rule under R9-22-1501(B) and Title VI compliance rule under R9-22-1501(M). Terms used in this Article are defined in Article 1 of this Chapter unless otherwise specified.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

### R9-22-1903. Application for Coverage

**A.** A person may apply by submitting a signed application to an Administration office.

**B.** The application date is the date the application is received at an Administration office or outstation location approved by the Director.

**C.** The provisions in R9-22-1405(B), (C) and (E) apply to this Section.

**D.** The applicant or representative who files the application may withdraw the application for coverage either orally or in writing. An applicant withdrawing an application shall receive a denial notice under R9-22-1904.

**E.** Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 45 days.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4).

### R9-22-1904. Notice of Approval or Denial

The Administration shall send an applicant a written notice of the decision regarding the application. This notice shall include a statement of the action, and:

1. If approved, the notice shall contain:
   a. The effective date of eligibility,
   b. The amount the person shall pay, and
   c. An explanation of the person's hearing rights specified in Article 8 of this Chapter.
2. If denied, R9-22-1501(F)(3) applies.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

### R9-22-1905. Reporting and Verifying Changes

An applicant or member shall report, as described under R9-22-1501(G)(3), (4), (5), and (6), to the Administration the following changes:

1. Change of address,
2. Change in income,
3. Change in employment status,
4. Change in school attendance if under age 22,
5. Change in Arizona state residency;
6. Change in first- or third-party liability which may contribute to the payment of all or a portion of the person's medical costs,
7. Admission to a public institution,
8. Admission to an Institution for Mental Disease,
9. Improvement in the person's medical condition,
10. Death,
11. Change in U.S. citizenship or immigrant status,
12. Change in disability status,
13. Change in impairment related work or other expenses, or
14. Any other change that may affect the member or applicant's eligibility.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

### R9-22-1906. Actions that Result from a Redetermination or Change

The processing of a redetermination or change shall result in one of the following actions:

1. No change in eligibility or premium,
2. Discontinuance of eligibility if a condition of eligibility is no longer met,
3. A change in premium amount, or
4. A change in the coverage group under which a person receives AHCCCS medical coverage.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

### R9-22-1907. Notice of Adverse Action Requirements

**A.** The requirements under R9-22-1501(J)(1) apply.

**B.** Advance notice of a change in eligibility or premium amount. Advance notice means a notice of proposed action that is issued to the member at least 10 days before the effective date of the proposed action. Except under subsection (C), advance notice shall be issued whenever an adverse action is taken to discontinue eligibility, or increase the premium amount.

**C.** Exceptions from advance notice. A notice shall be issued to the member to discontinue eligibility no later than the effective date of action if:

1. A member provides a clearly written statement, signed by that member, that services are no longer wanted.
2. A member provides information that requires termination of eligibility and a member signs a written statement waiving advance notice;
3. A member cannot be located and mail sent to the member's last known address has been returned as undeliver-

able subject to reinstatement of discontinued services under 42 CFR 431.231(d);
4. A member has been admitted to a public institution where a person is ineligible for coverage;
5. A member has been approved for Medicaid in another state; or
6. The Administration receives information confirming the death of a member.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1908. Request for Hearing**
An applicant or member may request a hearing under Article 8 of this Chapter for the following adverse actions:
1. The determination of a premium amount under R9-22-1920, and
2. Actions listed in R9-22-803.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1909. Social Security Number**
As a condition of eligibility, an applicant shall furnish a valid SSN.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1910. State Residency**
As a condition of eligibility, an applicant or member shall be a resident of Arizona.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1911. Citizenship and Immigrant Status**
As a condition of eligibility an applicant or member shall be a citizen of the United States, or shall meet requirements for qualified alien under A.R.S. § 36-2903.03(B).

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1912. Age**
As a condition of eligibility an applicant or member shall be at least 16 years of age, but less than 65 years of age.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1913. Premium**
As a condition of eligibility, an applicant or member shall pay the premium required under R9-22-1920.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1914. Income**
As a condition of eligibility, an applicant or member's countable income shall not exceed 250 percent of FPL. The Administration shall count the income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K with the following exceptions:
1. The unearned income of the applicant or member shall be disregarded,
2. The income of a spouse or other family members shall be disregarded, and
3. The deduction for a minor child shall not apply.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1915. Institutionalized Person**
A person is not eligible for AHCCCS medical coverage if the person is:
1. An inmate of a public institution if federal financial participation (FFP) is not available, or
2. Age 21 through age 64 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except when allowed under the Administration's Section 1115 IMD waiver with CMS.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1916. Non Payment of Premium**
As a condition of eligibility, an applicant shall not have unpaid premiums as defined under R9-22-1920.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1917. Applicant and Member Responsibility**
As a condition of eligibility, an applicant or member shall comply with the provisions under R9-22-1502(D) and R9-22-1502(F).

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1918. Additional Eligibility Criteria for the Basic Coverage Group**
An applicant or member shall meet the following eligibility criteria:
1. Disabled. As a condition of eligibility, an applicant or member shall be disabled. Disabled means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E), except employment activity, earnings, and substantial gainful activity shall not be considered in determining whether the individual meets the definition of disability.
2. Employed. As a condition of eligibility, an applicant or member shall be employed. Employed means that an applicant or member is paid for working and Social Security or Medicare taxes are paid on the applicant or member's work.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1919. Additional Eligibility Criteria for the Medically Improved Group**
As a condition of eligibility for the Medically Improved Group, a member shall:
1. Be employed. Under this Section, employed means an individual who:
   a. Earns at least the minimum wage and works at least 40 hours per month, or
   b. Has gross monthly earnings at least equal to those earned by an individual who is earning the minimum wage working 40 hours per month.
2. Cease to be eligible for medical coverage under R9-22-1918 because the member, by reason of medical improve-

ment, is determined at the time of a regularly scheduled continuing disability review to no longer be disabled; and
3. Continues to have a severe medically determinable impairment, as determined under regulations of the federal government.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1920. Premium Amount**
The Administration shall process premiums under Article 14 of this Chapter with the following exceptions:
1. A member who has countable income:
   a. Under $500, the monthly premium payment shall be $0.
   b. Over $500 but not greater than $750, the monthly premium payment shall be $10.
2. The premium for a member shall be increased by $5 for each $250 increase in countable income above $750.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1921. Enrollment**
The Administration shall enroll members under Article 17 of this Chapter. If a member has not paid a required premium, the Administration shall not grant a guaranteed enrollment period.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1922. Redetermination of Eligibility**
**A.** Redetermination. Except as provided in subsection (B), the Administration shall complete a redetermination of eligibility at least once a year.
**B.** Change in circumstance. The Administration may complete a redetermination of eligibility if there is a change in the member's circumstances, including a change in disability or employment that may affect eligibility.
**C.** Medical Improvement. If a member is no longer disabled under R9-22-1918, the Administration shall determine if the member is eligible under other coverage groups including the medically improved group.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

## ARTICLE 20. BREAST AND CERVICAL CANCER TREATMENT PROGRAM

**R9-22-2001. General Requirements**
**A.** Confidentiality. The Administration and ADHS shall maintain the confidentiality of a woman's records and shall not disclose a woman's financial, medical, or other confidential information except as allowed under R9-22-512.
**B.** Covered services. A woman who is eligible under this Article receives all medically necessary services under Articles 2 and 12.
**C.** Choice of health plan. A woman who is eligible under this Article shall be enrolled with a contractor under Article 17.

**Historical Note**
New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4).

**R9-22-2002. Treatment**
**A.** Breast cancer. Treatment for breast cancer shall conclude 12 months after the last provider visit for specific treatment for the cancer or at the end of hormonal therapy for the cancer, whichever is later. Treatment includes any of the following:
1. Lumpectomy or surgical removal of breast cancer,
2. Chemotherapy,
3. Radiation therapy, or
4. A treatment that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

**B.** Pre-cancerous cervical lesion. Treatment for a pre-cancerous cervical lesion, including moderate or severe cervical dysplasia or carcinoma in situ, shall conclude four months after the last provider visit for specific treatment for the pre-cancerous lesion. Treatment includes any of the following:
1. Conization,
2. LEEP,
3. Cryotherapy, or
4. A treatment that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

**C.** Cervical cancer. Treatment for cervical cancer shall conclude 12 months after the last provider visit for specific treatment for the cancer. Treatment includes any of the following:
1. Surgery,
2. Radiation therapy,
3. Chemotherapy,
4. A treatment that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

**Historical Note**
New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4).

**R9-22-2003. Eligibility Criteria**
**A.** General. To be eligible for the Breast and Cervical Cancer Treatment Program under this Article, a woman shall meet the requirements of this Article and:
1. Be screened for breast and cervical cancer through the WWHP on or after April 1, 2001;
2. Be less than 65 years of age;
3. Be ineligible for Title XIX under Articles 14 and 15;
4. Receive a positive screen under subsection (A)(1), a confirmed diagnosis by a WWHP physician, and need treatment for breast cancer, cervical cancer, or a pre-cancerous cervical lesion as specified in R9-22-2002;
5. Not be covered under creditable coverage as specified in Section 2701(c) of the Public Health Services Act (42 United States Code, Section 300gg(c)), January 5, 1999, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments; and
6. Meet the requirements under R9-22-1416 through R9-22-1418.

**B.** Ineligible woman. A woman is ineligible for Breast and Cervical Cancer Treatment Program under this Article if the woman:
1. Is an inmate of a public institution and federal financial participation (FFP) is not available,
2. Is age 21 through age 64 and resides in an Institution for Mental Disease as defined in R9-22-112, or
3. No longer meets an eligibility requirement under this Article.

**C.** Metastasized cancer. A woman's eligibility under this Article shall continue if a metastasized cancer is found in another part of the woman's body and that metastasized cancer is a known or presumed complication of the breast or cervical cancer.

**D.** Reoccurrence of cancer. A woman shall have eligibility reestablished after eligibility under this Article ends if the woman is screened under the WWHP program and additional breast or cervical cancer is found.

**E.** Ineligible male. A male is precluded from receiving screening and diagnostic services under the WWHP program and is ineligible under this Article.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4).

**R9-22-2004. Title XIX Application Process**

**A.** Title XIX application. A woman may apply for eligibility under this Article by submitting a complete Title XIX application as specified in R9-22-1405.

**B.** Submitting the Title XIX application. The woman may complete and submit a Title XIX application at the time of the WWHP screening or mail the application directly to the Administration.

**C.** Date of application. The date of the Title XIX application is the date of the diagnostic procedure that results in a positive diagnosis for breast cancer, cervical cancer, or a pre-cancerous cervical lesion.

**D.** Responsibility of a woman who is applying or who is a member. A woman who is applying or who is a member shall:

1. Give complete and truthful information on the Title XIX application;
2. Comply with the requirements of this Article;
3. Provide medical insurance information including any changes in medical insurance; and
4. Inform the Administration about a change in address, residence, and alienage status.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4).

**R9-22-2005. Approval, Denial, or Discontinuance of Eligibility**

**A.** Eligibility determination. The Administration shall determine eligibility under this Article within seven days of receipt of a complete Title XIX application.

**B.** Approval. If a woman meets all the eligibility requirements in this Article, the Administration shall provide the woman with an approval notice. The approval notice shall contain:

1. The name of the eligible woman,
2. The effective date of eligibility, and
3. Information regarding the woman's appeal and request for hearing rights.

**C.** Denial. If the Administration denies eligibility, the Administration shall provide the woman with a denial notice. The denial notice shall contain:

1. The name of the ineligible woman,
2. The specific reason why the woman is ineligible,
3. The legal citations supporting the reason for the denial,
4. The location where the woman can review the legal citations, and
5. Information regarding the woman's appeal and request for hearing rights.

**D.** Discontinuance.

1. Except as specified in subsection (D)(2), if a woman no longer meets an eligibility requirement under this Article, the Administration shall provide the woman an advance Notice of Action no later than 10 days before the effective date of the discontinuance.
2. The Administration may mail the Notice of Action no later than the effective date of the discontinuance if the Administration:
   a. Receives a written statement from the woman voluntarily withdrawing from AHCCCS,
   b. Receives information confirming the death of the woman,
   c. Receives returned mail with no forwarding address from the post office and the woman's whereabouts are unknown, or
   d. Receives information confirming that the woman has been approved for Title XIX services outside the state of Arizona.
3. The Notice of Action shall contain the:
   a. Name of the ineligible woman,
   b. Effective date of the discontinuance,
   c. Specific reason why the woman is discontinued,
   d. Legal citations supporting the reason for the discontinuance,
   e. Location where the woman can review the legal citations, and
   f. Information regarding the woman's appeal and request for hearing rights.

**E.** Request for hearing. A woman who is approved, denied or discontinued for the Breast and Cervical Cancer Treatment Program may request a hearing under Article 8.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4).

**R9-22-2006. Effective Date of Eligibility**

The effective date of eligibility is the later of:

1. The first day of the month of a Title XIX application;
2. The first day of the first month the woman meets all the eligibility requirements in this Article; or
3. January 1, 2002.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4).

**R9-22-2007. Redetermination of Eligibility**

**A.** Redetermination. Except as provided in subsection (B), the Administration shall complete a redetermination of eligibility at least once a year. If a woman continues to meet the requirements of eligibility for the Breast and Cervical Cancer Treatment Program, the Administration shall notify the woman of continued eligibility for another year. A woman is not required to be screened for breast and cervical cancer through the WWHP under R9-22-2003 at redetermination.

**B.** Change in circumstance. The Administration shall complete a redetermination of eligibility if there is a change in the woman's circumstances, including a change in treatment under R9-22-2002, that may affect eligibility.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4).

## ARTICLE 21. TRAUMA AND EMERGENCY SERVICES FUND

*Article 21, consisting of Sections R9-22-2101 through R9-22-2103, made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).*

**R9-22-2101. General Provisions**

**A.** A.R.S. § 36-2903.07 establishes the Administration as the authority to administer the Trauma and Emergency Services Fund.

**B.** The Administration shall distribute 90% of monies from the trauma and emergency services fund to a level I trauma center, as defined in subsection (F) of this Section, for unrecovered trauma center readiness costs as defined in subsection (F) of this Section. Reimbursement is limited to no more than the amount of unrecovered trauma center readiness costs as determined in subsections (D) and (E) of this Section. Unexpended funds may be used to reimburse unrecovered emergency room costs under subsection (C) of this Section.

**C.** The Administration shall distribute 10% of monies from the trauma and emergency services fund, for unrecovered emergency services costs, to a hospital having an emergency department, using criteria under R9-22-2103. Reimbursement is limited to no more than the amount of unrecovered emergency services costs as determined in R9-22-2103. The Administration may distribute more than 10% of the monies for unrecovered emergency room costs when there are unexpended monies under subsection (B) of this Section.

**D.** The Administration shall distribute a reporting tool and guidelines to level I trauma centers to determine, on an annual basis, the unrecovered trauma center readiness costs for level I trauma centers as defined in subsection (F) of this Section. The reporting time-frame is July 1 of the prior year through June 30 of the reporting year. A level I trauma center shall submit the requested data and a copy of the most recently completed uniform accounting report under A.R.S. § 36-125.04 to the Administration no later than October 31 of each reporting year.

**E.** When a level I trauma center closes in a county where there are one or more level I trauma center(s) remaining in operation, the following shall occur:
1. The closing level I trauma center shall submit the requested data under subsection (D) of this Section for the months of the reporting time-frame in which it met the definition of a level I trauma center, and
2. The data under subsection (D) of this Section, which is submitted by the closing level I trauma center, shall be added to the remaining level I trauma center(s) in that county for the current reporting time-frame only.

**F.** In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:
1. "Level I trauma center" means any acute care hospital that:
   a. Provides in-house 24-hour daily dedicated trauma surgical services as defined in A.R.S. § 36-2201(26) pertaining to a trauma center, or
   b. Is recognized as a rural regional trauma center that was providing formal organized trauma services on or before January 1, 2003.
2. On or after January 1, 2005, "level I trauma center" means any acute care hospital designated by the Arizona Department of Health Services as a level I trauma center.
3. "Unrecovered trauma center readiness costs" means losses incurred treating trauma patients:
   a. Determined in accordance with Generally Accepted Accounting Principles,
   b. Based on both clinical and professional costs incurred by a level I trauma center necessary for the provision of level I trauma care, and
   c. Based on administrative and overhead costs directly associated with providing level I trauma care.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).

**R9-22-2102. Distribution of Trauma and Emergency Services Fund: Level I Trauma Centers**

**A.** On or after November 1, 2003, the Administration shall distribute monies, under R9-22-2101(B), to level I trauma centers using monies available in the trauma and emergency services fund at the time of payment. The Administration shall take into consideration the proportion of those hospitals' trauma case volume. The Administration shall:
1. Recalculate the November 2003 payments in July 2004 using the formula in subsection (B) of this Section;
2. Recoup November 2003 overpayments by reducing the July 2004 distributions under subsection (C) as appropriate; and
3. Redistribute recouped funds, with the July 2004 payment, to level I trauma centers underpaid in November 2003.

**B.** On or after January 31 of each year, the Administration shall distribute monies, under R9-22-2101(B), to level I trauma centers using monies available in the trauma and emergency services fund at the time of payment. The Administration shall determine each hospital's unrecovered trauma center readiness costs for the current fiscal year using data from the most recent reporting year as provided under R9-22-2101(D) and (E). The proportion of each hospital's share of the fund for unrecovered trauma center readiness costs is determined after considering:
1. The professional, clinical, administrative, and overhead costs directly associated with providing level I trauma care, and
2. The volume and acuity of trauma care provided by each hospital.

**C.** On or after July 31 of each year, the Administration shall distribute monies to level I trauma centers using monies, under R9-22-2101(B), available in the trauma and emergency services fund at the time of payment according to the proportions calculated and used for the January payments in the same year, under subsection (B) of this Section.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).

**R9-22-2103. Distribution of Trauma and Emergency Services Fund: Emergency Services**

On or after June 30 of each year, the Administration shall distribute monies available in the trauma and emergency services fund at the time of payment as follows:
1. As allocated under R9-22-2101(C),
2. To hospitals that had an emergency department from July 1 through June 30 of the prior year, and
3. On a pro rata share of each hospital's uncompensated care as a percentage of the total statewide uncompensated care provided by hospitals under subsection (2) as reported in the uniform accounting reports to the Arizona Department of Health Services under A.R.S. § 36-125.04.

**Historical Note**
New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).